Chapter 1. Introduction

Beginning in the early 1990's, Indiana's state government earnestly began to pursue a shift of long-term care service delivery away from the traditional, institutional settings of state-operated facilities, nursing homes, intermediate care facilities for the mentally retarded, and group homes, in favor of the then less-familiar community setting. It began with the controversial closing of Central State Hospital in 1992, which was later applauded for the significant, positive outcomes achieved for so many of its residents who were previously believed to be unable to function successfully in the community. It continued with the closing of New Castle State Developmental Center and the Northern Indiana State Developmental Center.

Many changes have occurred since that time. At the direction of Governor Frank O'Bannon, the Indiana Family and Social Services Administration has aggressively pursued reform for all of the at-risk populations for which it provides services. Medicaid community programs have been expanded, state-operated facilities have been closed, eligibility for the Medicaid disability program has been expanded, a prescription drug benefit has been developed, services for persons with mental illness have been expanded, and much more.

Despite this level of effort, however, Indiana continues to lag behind the rest of the country in providing a comprehensive array of long-term care services that includes not only the traditional healthcare service settings, but also affordable housing and sufficient in-home and community-based service options. A full array of services is needed in order to facilitate consumer choice and independence, and to promote quality of care and quality of life for Hoosiers who are at risk for, or already in need of, long-term care services. It is noteworthy that a nationally recognized consultant in the long-term care field recently predicted that, at current rates of growth and policy change, Indiana would not have a balanced long-term care system, where consumers have real choice in selecting community care settings, for another 30 to 40 years.[1]

Evidence of this service gap is the large proportion of Indiana's frail elderly and persons with disabilities who continue to remain in institutions**.** This imbalance was created by years of institutional bias, driven by both Federal and state regulation, and a general resistance to changing from what has been considered by many to be a very "safe" medical model of care to one that favors consumer choice and independence, and therefore includes some level of healthcare "risk".

There are a number of significant obstacles that make reform of its long-term care service delivery system in Indiana so difficult to accomplish. Affordable housing and community care services in Indiana are extremely limited, making true consumer choice generally unavailable. There is, in fact, no publicly-funded adult program in Indiana that operates without a waiting list for persons in need of that/those services. Specific examples of programs whose demand far exceeds the supply are: the state-funded CHOICE program; Medicaid Home and Community-Based Services Waivers; and Section 8 Housing. Moreover, even Medicaid disability benefits in Indiana are more difficult to obtain than in 48 other states, resulting in a disproportionately high number of chronically and seriously ill Indiana residents without any form of healthcare coverage.

Similarly, services and funding opportunities available for children who are seriously emotionally disturbed or who are considered to be at risk of abuse, neglect, delinquency, developmental delay, developmental disability, or academic failure in Indiana are not available or are not managed consistently in each of Indiana's 92 counties. As with many of Indiana's long-term care services for adults, children are often removed from their home environment to receive costly institutional

care, even though there are service funds available for treating children in the community. In contrast, Indiana has, in recent years, enjoyed national recognition for its leadership in enrolling children into the children's health insurance program (Hoosier Healthwise), its home visitation services (Healthy Families), and its early intervention services (First Steps). Each of these services promotes healthy child development, preventive or early intervention strategies to prevent long-term care of out-of-home placements and provision of services in the community. This recognition and success have not been as evident in maximizing Federal funding streams that would expand services in a cost effective manner to Hoosier children. The most notable of these are the Medicaid Rehabilitation Option and the Early and Periodic Screening, Diagnosis, and Treatment components of the Medicaid program. In each instance, under-utilization of these services is noted in some parts of the State. These Federal funds are available, but have not been pursued consistently by the State that could further promote community care services for at-risk children.

To increase the momentum for expanding community capacity and consumer choice, the Indiana Family and Social Services Administration, in an unprecedented effort, has teamed up with the U.S. Department of Health and Human Services to pursue innovation and to firmly establish lasting change. Three Federal grants were sought and subsequently awarded, to assist Indiana in once-and-for-all overcoming the long-standing barriers that have made reform so elusive in the past. At the lead in this effort, is the appointment by Governor O'Bannon of a bi-partisan, broad-based Commission, representing experts in fields that have never before been convened, to direct and coordinate the elements of long-term care in Indiana that have long been disconnected or altogether absent. A copy of Governor O'Bannon's Executive Order is included in the Appendices.

The Commission's work is intended to complement, and not duplicate, the valuable work already accomplished by so many others, such as the Senate Bill 317 Commission, the State-Operated Facilities Council, the Indiana Family and Social Services Administration's Long-Term Care Task Force, and the 2002 Commission on Caregivers. Specifically, the Governor's Commission on Home and Community-Based Service's work assignments focus on the "next steps" of building community capacity, eliminating barriers, and developing partnerships and systems that will support consumer choice. Their time-lines have been short, and their assignments daunting. Nevertheless, it is the belief and hope of many that the leadership of the Commission will create the impetus that is needed to finally tip the scales away from traditional modes of care and toward more responsive, consumer-driven, outcomes-oriented community care.

1.1 Background

The policy issues related to "long-term care" in Indiana cannot be fully understood without providing a definition of the term. In addition, while each state and program describes long-term care somewhat differently, all typically share the same common elements. One of the more comprehensive definitions[2] is as follows:

> "Long-term care is…a broad range of help with daily activities that chronically disabled individuals need for a prolonged period of time. These primarily low-tech services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning. The services include assistance with basic activities of daily living (ADLs), such as bathing, dressing, eating, or other personal care. Services may also help with instrumental activities of daily living (IADLs), including household chores like meal preparation and cleaning; life management such as shopping, money management, and

> medication management; and transportation. The services include hands-on and standby or supervisory human assistance; assistive devices such as canes and walkers; and technology such as computerized medication reminders and emergency alert systems that warn family members and others when an elder with a disability fails to respond. They also include home modifications like building ramps and the installation of grab bars and door handles that are easy to use."

Persons who utilize long-term care services (regardless of funding source) include: the frail elderly; adults and children with physical disabilities; adults and children with developmental disabilities; adults and children with mental illness; and children and their families who are at risk of involvement in the child protective system, the juvenile justice system, or through academic failure in the education system.

Given the scope, variation, and funding source among long-term care services, it is difficult to estimate total expenditures for all services in Indiana. Indiana Medicaid expenditures alone for long-term care services totaled $1.81 billion in state fiscal year 2000[3]. Of that, approximately $773 million was spent on nursing home care, $289 million on institutional care for persons with developmental disabilities, and only $101 million on home and community-based services (waiver) care. Another $38 million was spent by Indiana's CHOICE program[4] to help people remain in the community. Perhaps more revealing, however, are the number of Medicaid recipients served by setting: namely 46,200 in nursing homes; 5,759 in intermediate care facilities for the developmentally disabled (state operated facility, large private facilities, and small group homes); and only 5,089 receiving community services through the Medicaid Home and Community-Based Services Waiver program.

The payment of services for abused, neglected, and delinquent children is paid through the 92 county family and children's funds, the revenue source of which is the county property tax. Due to significant local outcry because of the runaway costs of these funds throughout the State in the early 1990s, aggressive action was taken to constrain the growth of the local property tax rates. That provided an impetus for developing family-focused, community-based services, prevention programming, and increasing Federal reimbursement through the foster care placement programs. In state fiscal year 2000, over $27.5 million was expended in the Healthy Families home visitation program. To complement this very positive and beneficial effort to prevent abuse, neglect, and delinquency, the First Steps program expended over $42.5 million (also in state fiscal year 2000) to decrease, ameliorate, or early intervene when risk factors known to impact developmental delays or disabilities are identified in children ages 0-2. These efforts, while focused in the right direction, must be considered in the perspective of over $160 million spent in calendar year 2000 on private institutional placements for abused, neglected, and delinquent children, the amount of which does not include costs for children in state-operated facilities, correctional facilities or foster care. Foster care in the community for these children totaled almost $75 million in state fiscal year 2000, while in-home services for children in the child protective system, the juvenile justice system or for children who were at-risk of entering those systems approximated only $45 million. Clearly the direction is correct, but the effort is lagging behind the rest of the country, posing significant expense to both the child and the taxpayer. These figures do not include mental health services either at the community- or state-operated facility level.

Since the early 1980's, the Federal Centers for Medicare and Medicaid Services[5] have allowed states to use Medicaid funding to creatively design community-based programs that provide real alternatives to traditional forms of institutional care, such as nursing home, group home, intermediate care facility for the mentally retarded, and state-operated facilities (all of these are

typically defined as "institutional care" for purposes of the Medicaid Program). Many other states have embraced this flexibility wholeheartedly, having successfully shifted the long-term care service balance for their residents to one that favors more desirable and less-costly care in one's own home or other community setting over traditional and less-desirable institutional settings.

Across the country, consumer frustration with states' unwillingness, inability, and/or slow progress to embrace and develop viable and available community service options for its residents has been mounting in recent years. This frustration is evidenced by an increasing amount of litigation, which culminated in a key disability rights decision, *Olmstead v. L.C.*, issued on June 22, 1999 by the United States Supreme Court. A brief summary offered by the Center for Healthcare Strategies, Inc.[6] is provided below:

> *"The lawsuit, brought against the State of Georgia, questioned the state's continued institutionalization of two disabled individuals after physicians had determined that they were ready to return to the community. The Supreme Court described Georgia's action as "unjustified isolation", and determined that the state had violated these individuals' rights under the Americans with Disabilities Act (ADA).*
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> *The Court explained that unjustified isolation was a form of discrimination. It reflected two judgments: First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.*
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> *The Supreme Court was careful to say that the responsibility of states to provide healthcare in the community was "not boundless". States were not required to close institutions nor were they to use homeless shelters as community placements. Without imposing specific requirements, the Court said that if "…the state were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, the reasonable modifications standard [of the ADA] would be met." The Court specified that the state must provide community placement and services without displacing others on a waiting list for similar benefits and without unduly burdening the state's resources.*
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> *Although the Olmstead decision confirmed the ADA's community integration mandate, the words "housing" or "supportive housing" do not appear in the decision. Instead, the Supreme Court used terms such as "community placements" and "less restrictive settings". Nonetheless, the Olmstead decision could have a profound impact on future state policies and approaches to provide community-based housing and support services for people with significant disabilities. As a result of the Olmstead decision, thousands of people currently living in "more restrictive settings" such as public institutions and nursing homes must be offered housing and community-based supports that are consistent with the integration mandate of the ADA."*

As described above, the *Olmstead* decision was a landmark for guiding the delivery of publicly-funded long-term care services, thereby further impressing upon states the need to respond to the decision quickly, clearly, and decisively.

1.2 The Indiana Family and Social Services Administration

Before and since the time that the *Olmstead* decision was rendered, the Indiana Family and Social Services Administration has engaged in a number of initiatives specifically targeted to increase community care options for individuals who depend upon public assistance for their services. These include, but are not limited to:

- *The Senate Bill 317 Task Force* – Appointed by Governor O'Bannon in 1997, this group was charged with developing a comprehensive plan for services for people with developmental disabilities, while assisting the Indiana Family and Social Services Administration in the simultaneous closure of two state-operated facilities.
- *The Governor's Council on State-Operated Care Facilities* – Created in 1999 in response to on-going concerns about the future of the nine (9) remaining state-operated care facilities for persons with developmental disabilities, Governor O'Bannon appointed a special council to develop a long-range plan to ensure the provision of high quality, cost-effective care in the nine facilities.
- *Long-Term Care Task Force* – In 2000, Governor O'Bannon appointed a task force to evaluate a number of long-term care issues and to oversee the development of the Medicaid Waiver application for assisted living and adult foster care that was mandated by House Enrolled Act 1197.
- *The Hoosier Rx Program* – Implemented in 2000, this program provides prescription drug assistance for low-income seniors. It is funded through Tobacco Settlement money.
- *House Enrolled Act 1767 Continuum of Care for the Elderly and Disabled* – Passed in 2001, this Act mandated the Indiana Family and Social Services Administration to develop a plan that would ensure that services provided under its programs match the needs of the individuals receiving the services. Additionally, it calls upon the agency to file a preliminary and final report.
- *House Enrolled Act 1950 Medicaid Buy-In* – Also passed in 2001, this Act provides for an expansion of the Medicaid disability program to include certain working individuals with disabilities as authorized by the Federal Ticket to Work and Work Incentives Improvement Act.

It is important to note that members of the Indiana General Assembly continue to have great interest in long-term care issues and continue to request information and action from the various agencies responsible for some part of the shift toward community-based care.

The Indiana Family and Social Services Administration has initiated and pursued numerous other policy changes and programs that have led to improved health outcomes and quality of life for many of Indiana's residents who depend upon public assistance for their healthcare and social needs. In addition, while limited by serious budget constraints in recent years, the Agency continues to actively and aggressively pursue program and system reforms that will collectively and significantly improve the long-term care service delivery system in Indiana.

Evidence of this commitment to change is the Agency's diligent pursuit and subsequent award of three grants offered by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services. The three grants and a brief description of each are as follows:

- *Real Systems Change Grant.* The purpose of this grant is to: establish a Commission that will provide a constant forum for interaction with consumers of long-term care services and their advocates; identify best practices and barriers to community integration and consumer control; provide oversight and monitoring; assist in the implementation of a series of mini-grants to local communities; and make further recommendations for policy and funding actions.

- *Nursing Home Transitions Grant.* The purpose of this grant is to: develop models for the diversion of persons from nursing home care and for the transition of nursing home residents back into the community; provide training, education, and outreach; collaborate with nursing home associations, housing partners, assisted living facilities, and community stakeholders; develop a team to design and facilitate the transition process; identify and select candidates to be transitioned and/or diverted; and evaluate and prepare reports.

- *Community Personal Assistance Services and Supports (CPASS) Grant.* The purpose of this grant is to: provide outreach and information about consumer-directed care services; develop a consumer-directed personal assistance services model and the supporting infrastructure; establish a fiscal intermediary structure for attendant care workers; provide enhanced training; develop quality assurance, conflict resolution, and emergency assistance protocols; and develop a system for outcomes-based reporting.

1.3 Governor's Commission on Home and Community-Based Services

On July 30, 2002, Governor Frank O'Bannon made the announcement that he had formed the Governor's Commission on Home and Community-Based Care. It has been funded primarily by the Real Systems Change Grant, but also received funds from the Nursing Home Transitions and Community Personal Assistance Services and Supports grants for its role in coordinating all three initiatives; it has used no state funds.

The Commission is both broad-based and bi-partisan. It has twenty-one members, representing consumers, advocates, clergy, legislators, government, business, the service industry, public policy, education, and the medical and legal professions. Each member was selected for his/her unique perspective on the many issues and obstacles facing Indiana's frail seniors, children and adults with disabilities, persons with mental illness, and children and families who are considered to be at-risk. A complete list of Commission members can be found in the Appendices.

The purpose of the Commission was to develop short- and long-term strategies to create or expand community options for persons at risk of being institutionalized, or for those currently in a nursing home or other institutional setting within Indiana's long-term care service delivery system. Its specific functions include: identification of the policy issues surrounding institutionalization; compilation of key statistics and other resource materials; identification of successful and innovative programs that break traditional housing and service barriers; solicitation of consumer perspective; and development of funding and policy strategies.

While it has already been noted that there have been other efforts focused on the transition to community-based services, this is the first time that multiple agencies have focused their time and resources toward enhancing and expanding community services to support persons living in the community. Additionally, it is the first effort at developing cross disability community services.

The Commission has met at least monthly beginning in August 2002. It has produced an Interim Report presented to Governor O'Bannon in December 2002, and now this June 2003 report. The Commission will meet one last time in December 2003 to examine and evaluate progress made on both the short- and long-term recommendations presented in both reports, and to evaluate the progress made on systems change through the mini-grants and the impact that Senate Bill 493 (2003) has had on Indiana's home and community-based service system.

The Commission accomplished its work with the assistance of five special task forces that were assigned specific policy issues, and a Consumer Advisory Committee that was specifically designed to research and evaluate the relevant policy issues, advise the Commission, and increase the scope and substance of Hoosier participation to ensure that all with interest are involved in formulating the solutions needed to break new ground in Indiana. Each of the five task forces were devoted to specific policy areas of concern, while the committee was comprised solely of consumers and advocates with the express purpose of evaluating all task force work and advising the Commission. A complete listing of the task forces and the Consumer Advisory Committee, their specific purpose and function, and their membership can be found in the Appendices.

1.4 Mission Statement and Guiding Principles

At their first meeting, the Commission realized the importance of focusing on the assignments expressly presented them by Governor O'Bannon, and building upon and not duplicating the significant body of work already produced by numerous, preceding task forces and commissions. Moreover, they quickly came to appreciate the existing skepticism of many regarding the Commission and whether their work would, in fact, provoke lasting change and improvement in policy areas that have been frustratingly slow to evolve in Indiana.

In direct response to these challenges, the Commission resolved to develop recommendations that would transcend political interests and time-lines and that would complement (not duplicate) the continuing work of others, thereby creating an impetus for change that would be difficult to restrain.

The Commission's commitment is memorialized in a mission statement (Preamble) and five guiding principles, which were specifically developed to assist them in establishing clear and meaningful boundaries and direction for their work.

The Commission on Home and Community-Based Services exists to pursue common and aggressive actions that will facilitate immediate and lasting change in long-term care services in Indiana. The Commission's work is targeted to persons who already are, or who may sometime in the future depend upon long-term care services. The Commission will develop these recommended actions based upon a public policy that makes sense, is financially accountable, and promotes personal choice by the persons receiving or at risk of receiving these services. The Commission will build upon the good work already accomplished by other commissions and groups and will be guided by activities and implementation strategies that improve the lives of people currently affected by these services. Each recommended action is intended to help overcome the already well-known systemic barriers, current policies and procedures, and organizational practices that are obstacles to change.

Guiding Principle 1: Authority and Power of the Commission. The Commission recognizes that additional statutory or executive authority may be needed to implement the recommended activities and strategies that can improve service delivery for those persons who require or are at-risk of requiring long-term care services. However, the Commission also recognizes that true power comes in the ability to facilitate problem-solving in a meaningful and common-sense manner that transcends political, financial, and bureaucratic concerns. The Commission will articulate each strategy and recommended action step in a clear and concise manner that also identifies the consequences for refusing to enact the recommended action.

Guiding Principle 2: Accountability. The Commission will base its decisions upon information that is irrefutable so that a consensus can be achieved to bring about the systems change that is desired and that meets legal, financial, programmatic, and human expectations. Clear, measurable objectives will be identified, and timetables will be established that will form the basis of a three (3) to five (5) year action phase that is reasonable, realistic, and attainable. Any additional action phases will be a natural consequence of this initial phase, thereby reducing the likelihood of later modifying a longer-term strategy. The Commission understands the reality of budget constraints and will advocate current resource maximization that includes creative state plan amendments and waiver submissions prior to the development of any budgetary request.

Guiding Principle 3: Personal Choice. The Commission will identify strategies that promote the development of sufficient and quality care alternatives necessary to ensure true personal choice in all service settings.

Guiding Principle 4: Collaboration. Collaboration must exist throughout all levels of state and community agencies and organizations involved in services for long-term care. The Commission will serve as a "best practices and innovation" forum to ensure accurate information and education so training and organization culture changes can promote meaningful and real systems change. The Commission recognizes the importance and value of staff in each agency and organization involved in long-term care service delivery and endorses systems changes that allow staff to assist long-term care consumers to best meet their needs according to personal preferences.

Guiding Principle 5: Prevention and Early Intervention. The Commission is committed to the expansion of prevention and early intervention services that can decrease the incidence of causative factors that lead to a person's need for long-term care services.

1.5 Mini-Grants

As part of the Real Systems Change Grant funded by the Centers for Medicare and Medicaid Services, the Commission worked with the Indiana Family and Social Services Administration to develop and award a number of mini-grants. These mini-grants were designed to create community partnerships, provide incentives for public/private partnerships, and serve to encourage innovation at the community level between community stakeholders.

The mini-grants were directed to the three major goals of the Commission:

- To develop community capacity in the areas of community living arrangements, affordable housing, transportation, supported employment, and caregiver support.

- To develop systems that support consumer choice and consumer-directed care.
- To develop innovative systems that identify and propose solutions to eliminate barriers to service.

The Commission and the Indiana Family and Social Services Administration also accepted proposals that addressed other areas that proposed, supported, and validated enduring system changes. Grants were considered if they fostered collaboration among community partnerships. These were generally smaller-sized grants rather than larger grants and were a maximum of $40,000 per grant. Innovation was favored over traditional, and initiating new capacity was favored over simply expanding existing capacity. The focus was on maximizing and leveraging the funds by working to match other funding sources in the local communities.

There were two rounds of grant solicitations; one in December 2002, and one in March 2003. The first round of mini-grants was awarded in February to twelve different communities and totaled more than $430,000. The second round of grants was awarded in May to eleven different communities and totaled more than $320,000. The grants were rated by a committee of staff of the Indiana Family and Social Services Administration and consumers from the Consumer Advisory Committee.

Please see the Appendices for additional information on the mini-grants.

1.6 Commission Web Site and Reference Information

The Indiana Family and Social Services Administration has developed and maintains a web site expressly for the Governor's Commission on Home and Community-Based Services. This web site is: http://www.in.gov/fssa/community/ and includes viewing and downloading capability for the December 2002 Interim Report and this June 2003 report; meeting schedules, agenda and minutes; task force meetings and other information; information on the mini-grant solicitation; and other resource and informational material.

The Commission has also begun a reference and website list of relevant literature and other documents that have been published on one or more of the long-term care topics being researched and studied. This list can be found in the Appendices.

Chapter 2. Status of Recommendations Presented in the December 2002 Interim Report

During its first five meetings, the Governor's Commission on Home and Community-Based Services worked through a number of short-term actions that could be taken to begin the process for creating lasting systems change and community capacity. It was this "low hanging fruit" that formed the set of preliminary recommendations that were sent to the Governor in December 2002 for immediate implementation. All of these were identified as low-cost and/or administratively simple to execute but nonetheless important for promoting long-term care service delivery reform in Indiana.

All sixteen recommendations are restated below. Followed by each recommendation is a brief description of the most recently available status of implementation, any obstacles that have been encountered and additional steps needed to overcome the obstacles.

1. **Make financial eligibility for the Medicaid Aged and Disabled Waiver the same as for Medicaid-funded nursing home placements by implementing spousal impoverishment protections.** Targeted completion date: February 1, 2003.

   Status: Complete
   - Waiver approval received on February 24, 2003.
   - Waiver amendment effective date, January 1, 2003.
   - All county caseworkers have been notified of this change.
   - While the spousal impoverishment protection has been included in the Medicaid Aged and Disabled Waiver, work must still continue in ensuring uniform application by both Area Agency on Aging Case Managers and Division of Family Resources Field Staff.

2. **Raise the monthly eligibility standards for the Medicaid Aged and Disabled Waiver to 300% Supplemental Security Income amount. Complete a comprehensive fiscal impact analysis.** Targeted completion date: February 2003 for a comprehensive fiscal impact analysis.

   Status: Complete
   - A comprehensive fiscal impact analysis was completed in February 2003. Further refinement to the analysis was completed and presented to the Commission on March 27, 2003.
   - Funding has not yet been identified.
   - Senate Enrolled Act 493 mandates the implementation of 300% SSI, effective July 1, 2003.

3. **The Indiana Family and Social Services Administration should request approval from CMS to allow the certification and quality monitoring process that is currently in place for adult day services to serve as a substitute for state licensure**. Targeted completion date: January 15, 2003 for a written letter of request to be submitted to the Centers for Medicare and Medicaid Services.

   Status: Complete
   - A letter was submitted to CMS on February 14, 2003.
   - Follow-up questions were responded to on March 19, 2003.

- CMS responded to the Indiana Family and Social Services Administration's questions regarding clarification of "homebound status", relating to Medicare coverage of home health services provided to dually-eligible beneficiaries who are also attending adult day services.
- Division of Disability Aging and Rehabilitation Services certifies all adult day service providers for the waivers, which meets the Federal requirements and allows the providers to qualify for Medicare home healthcare services under the homebound provisions without having a state license.

4. **The Governor should re-appoint the Indiana Low-Income Housing Trust Fund Board to fulfill the original charge presented in 1988 to make recommendations regarding long-term funding sources to capitalize the housing trust fund and to serve as a focal point for creating affordable housing opportunities state-wide to help low-income and persons at risk remain in and/or return to the community.** Targeted completion date: appointment of the Board before April 1, 2003 and submission of the Board recommendations to the Governor by October 1, 2003.

5. **The Indiana Family and Social Services Administration is to develop, submit, and implement a Medicaid Home and Community-Based Waiver for children with serious emotional disturbance.** Targeted completion date: June 1, 2003.

   Status:
   - The Indiana Family and Social Services Administration is working to complete the waiver application, develop a provider base to provide waiver services, and complete a plan to administer the new waiver.
   - The application process is on schedule to be submitted to CMS in late June 2003. The waiver will provide an opportunity to braid funding from DMHA, DOC, DOE, DCS and DFR to further develop and provide an intensive level of integrated comprehensive services and support for children with SED who meet an institutional level of care. Waiver services will be provided through developing local systems of care. New waiver services will include wraparound facilitation, respite, independent living skills, and family support.
   - A new position, Home and Community-Based Services/Seriously Emotionally Disturbed Manager, has been created. The position will be posted on June 23.
   - Workforce development is being addressed through initial meetings with a wide range of providers, families, and advocates.
   - During the first year of the model waiver, 50 youth will be served, growing to 200 within 3 years.
   - Administration of the waiver must consider certification and training of providers, implementing a uniform level of care determination process, managing waiver plans and budget, and implementing a quality improvement process.

6. **Expand access to Medicaid Rehabilitation Option funding to include state licensed, accredited, and/or certified child placement agencies.** Targeted completion date: July 30, 2003.

   Status:
   - Submission was made to CMS on December 27, 2002, retro-dated back to September 2002.
   - A teleconference with CMS revealed concerns with the residential treatment payment process and a need to revise the waiver submission. Revised state plan material has been

developed and is being finalized internally. The cover letter and revised plan amendment will be submitted to the Office of Medicaid Policy and Planning mid-June for submission to CMS.

7. **Maximize the use of the waiver granted by the Federal Government that promotes expansion and community-based services for children and utilize more fully the availability of the independent living funds authorized by Congress.** Targeted completion date: development of independent living guidelines by January 31, 2003; development of the administrative structure model by April 1, 2003; IV-E waiver with Adoption Assistance Program children beginning education by March 1, 2003.

   Status:
   - The Indiana Family and Social Services Administration continues to address both issues by modifying the child welfare policy manual. Staff have completed the first draft of the manual, addressing the requirements of the Independent Living Program. This material is planned for release beginning May 16, 2003. The material will also address all funding issues regarding potential match sources for the Federal dollars, as well as utilization of the IV-E waiver slots for children who would qualify for the Independent Living Program.
   - Program staff negotiated a $0.9 million match from public utility overcharge settlement agreement for IL room and board funds to permit full drawdown of Chafee Independent Living Program grant.
   - Independent Living Program contract amendments were finalized in May 2003, which includes the Proliance settlement funds as a state match to increase utilization of Federal funds. Amendments addressed energy education and the provision of room and board costs for children ages 18-21 (who were in foster care when they were 14 to 18) and who now need assistance.
   - The Independent Living Program Conference is scheduled for June 23 and June 30, 2003 for foster youth, foster parents, case managers, CASA volunteers, and service providers. The conference will provide important information about opportunities and assistance available to help teenage youth and is sponsored by the Indiana Family and Social Services Administration, Ball State University, and Prevent Child Abuse of Indiana.

8. **The State should revise, simplify, and make consistent the current waiver process and payment methodology for Medicaid transportation providers.** Targeted completion date: June 30, 2003.

   Status:
   - Based on feedback from the provider community about the current complexity for documentation and tracking of driver time and mileage, as well as concerns about the cost of transportation services, the Indiana Family and Social Services Administration's Bureau of Developmental Disabilities Services reviewed the procedures associated with Driver and Transportation Services.
   - In an effort to simplify transportation services, the following revisions will be made effective July 1, 2003. Specific actions taken are below:

     <u>Individuals in Residential Settings with 24 hours a day/7days a week</u>:
     Monthly Rate is $150 or $300 based on ability to transfer into a vehicle or need for accommodations.

     <u>Individuals in Residential Settings with LESS than 24 hours a day</u>:

$8.91 for the first round trip of the day up to 31 days a month.
$2.00 for the second round trip up to 31 days.

Individuals in Day Services Only:
$8.91 for the first round trip up to 23 days a month.
$2.00 for the second round trip up to 23 days a month.

- The Indiana Family and Social Services Administration is still working with EDS, the State's Medicaid contractor on developing/revising the waiver procedure codes. The Indiana Family and Social Services Administration believes that transportation has been revised and simplified. The new process will be more consistent for Medicaid transportation providers.

9. **The Medicaid Assisted Living Waiver for Persons Who Are Aged and Disabled should be quickly evaluated to identify the participation barriers and then be modified as necessary to successfully promote, develop, and support the Medicaid Assisted Living Waiver services to the fullest extent possible.** Targeted completion date: begin a comprehensive analysis of provider and consumer concerns and program barriers immediately; develop a comprehensive strategy for February 1, 2003; implement all changes by June 1, 2003.

   Status:
   - To date, there are 51 persons being served on this Waiver and there are 16 providers.
   - Additional barriers that have been identified are Medicaid spenddown and the rate structure. The Office of Medicaid Policy and Planning and Division of Disability Aging and Rehabilitation Services are investigating the use of patient liability instead of spenddown (as is done in nursing facilities) since most assisted living providers are more familiar with this concept.
   - The rate concerns are being addressed through planned provider education training and a reorganized and streamlined information and application packet.
   - CMS reviewed this waiver May 11, 2003 through May 14, 2003. In general, the review was positive. Reviewers had a few positive comments and several recommendations. A formal report will be received in 60-90 days.
   - EDS, the State's Medicaid contractor, is providing on-site assistance to AL providers on request, to assist with billing issues, and educating providers on how to work with spenddown and related billing issues.

10. **Fully define and develop the new congregate care option within the Aged and Disabled Waiver to ensure that this additional service and affordable housing component is viable and available.** Targeted completion date: develop a comprehensive strategy by February 1, 2003; implement all changes by June 1, 2003.

    Status:
    - A strategy was developed to include marketing the congregate care piece to providers of subsidized housing. The marketing plan will be completed by July 1, 2003.
    - A provider training piece is being developed by the Bureau of Aging and IN-Home Services outreach unit to target specific providers and provider groups for training.
    - A clarified definition of the service was developed to be included with the renewal documents for the Aged and Disabled Waiver.
    - Approval from CMS is pending, and an effective date of July 1, 2003 is anticipated.

- There is a freeze on all Medicaid Waivers, so broad utilization of this service within the next year is not likely.

11. **The Indiana Family and Social Services Administration should immediately examine the barriers to timely Medicaid reimbursement of services provided by small providers and focus their educational outreach on these small community providers. The Indiana Family and Social Services Administration should also develop a streamlined payment process for small providers that will facilitate a timely and trouble-free payment. Waiver providers should be brought together to provide feedback on the changes that the Office of Medicaid Policy and Planning is making in response to new HIPAA requirements. The group should have broad-based representation**. Targeted completion date: implement changes by May 1, 2003.

    Status:
    - EDS, the State's Medicaid contractor, provides regularly scheduled training and will conduct focus training as needed and based on staffing availability with provider groups.
    - EDS will provide regularly-scheduled regional trainings for new and current providers and has provided on-site assistance as needed for particular providers (for example assisted living providers).
    - EDS is further developing a billing procedures manual for providers.
    - The Office of Medicaid Policy and Planning and Division of Disability Aging and Rehabilitation Services staff are developing a troubleshooting hierarchy process for case managers, providers, and waiver specialists to use in resolving level of care related billing issues.

12. **The Governor and the Indiana General Assembly should examine and assess existing legislation aimed at establishing Regional Transit Authorities (RTAs) across the State to all local taxing authority for the RTAs. A determination of the fiscal impact relative to expansion of services should be thoroughly examined as part of this assessment.** Targeted completion date: July 1, 2003.

    Status:
    - Representative Aguilera drafted HB 1665 for the benefit of the only current regional transportation authority in northwest Indiana. The bill would have granted a 1% increase in sales tax in Lake County, which would have raised approximately $6 million per year for the RTA. The bill was never given a hearing in the Ways and Means Committee and could not be revived in the Senate.
    - The RTA continues to exist, but it has no funding and therefore cannot accomplish much.

13. **The Department of Workforce Development should continue to maintain all resource centers with up-to-date, local employment opportunities and services. This information should be as "consumer-friendly" and comprehensive as possible and should include current resource materials prepared by partner agencies and organizations.** Targeted completion date: January 31, 2003.

    Status:
    - The Department of Workforce Development's Field Implementation staff has inventoried what is currently in place in the resource centers and has developed a comprehensive list. This was done with the help of local office staff and partner organizations.
    - A new guideline of minimum requirements has been drafted and will soon be shared with partner organizations for input.

- Progress has been slower than expected because the content hasn't been reviewed on a state-wide level in several years, so a more exhaustive approach has been preferred.
- The local Workforce Development office in at least one area has started monthly partner meetings, which are scheduled to continue every month to discuss how partners can help each other and how to access services. Shared trainings are being developed. Eligibility for each partner was discussed, as was the referral process.

14. **The Commission supports the application of a Real Systems Change mini-grant to focus on providing the administrative resources needed to facilitate and administer state-local application for all available Federal/state funds to support housing initiatives (i.e., Mainstream Vouchers - Section 8 vouchers for individuals with disabilities). If the project is not funded by a mini-grant, the Indiana Family and Social Services Administration should identify other resources to fund this project.** Targeted completion date: application for a mini-grant by April 1, 2003.

15. **All applicable Medicaid Home and Community-Based Services Waivers should include and implement the consumer-directed care service option.** Targeted completion date: implement by March 1, 2003.

    Status:
    - The Indiana Family and Social Services Administration waivers currently include a provision for self-directed care.
    - The Indiana Family and Social Services Administration is working with the CPASS taskforce to develop additional recommendations.
    - The Office of Medicaid Policy and Planning and EDS participated in a conference call with CPASS representatives to discuss payment mechanisms. The Indiana Family and Social Services Administration is working with the Department of Labor and Internal Revenue Service to finalize the process for enrollment and payment. This process, which includes training, enrollment, and fiscal intermediaries, is scheduled to be completed by July 31, 2003.
    - Drafts of the material have been completed by CPASS.
    - There are only minor obstacles regarding the lack of uniformity in the use of self-directed care in the CHOICE program. This issue will be addressed in the final documents from CPASS at the end of June 2003.

16. **The Indiana Family and Social Services Administration and the Indiana Department of Education should require inclusion of an age appropriate employment/vocational needs component as part of the person-centered plan/treatment plan/individual education program (IEP) for an individual receiving state funds or state-funded services, and/or services regulated by the State.** Targeted completion date: June 30, 2003.

    Status:
    - The rule that establishes an Individualized Support Plan (ISP) developed through the person-centered planning process, for all individuals receiving services through the Indiana Family and Social Services Administration's Bureau of Developmental Disabilities Section (BDDS) became effective May 21, 2003.
    - The use of the person-centered planning process will result in a more comprehensive view of the individual's needs; therefore, the Indiana Family and Social Services Administration will be looking at more vocational outcomes.
    - A pilot project with community rehabilitation programs is currently under consideration. A group consisting of providers, advocates, consumers, and the Indiana Family and

Social Services Administration staff are scheduled to meet June 12, 2003, to finalize payment points. A date to commence the pilot with two community rehabilitation programs from each of the five Vocational Rehabilitation (VR) regions will be identified by July 1, 2003, by the Deputy Director of Vocational Rehabilitation Services. The collaborative group has determined the essential elements of this process. This outcome-based system contains a strong person-centered planning component.

The Interim Report also briefly presented two (2) categories of additional recommendations that had not yet been developed. Nine (9) were considered to be additional short-term recommendations, and ten (10) were identified as long-term recommendations that required more complex and/or costly solutions. Most of the nineteen (19) recommendations were discussed extensively within the Task Forces during the months that followed the publication of the Interim Report in December 2002. Through these discussions, some of the recommendations were evaluated and then set aside, some were combined with other actions, some are included in the Issues and Going Forward chapters of this Report, and some were developed into the twenty-eight (28) new Actions that are presented in this Report.

Chapter 3. Presentation of New Actions

Since the publication of the Interim Report to the Governor in December 2002, the Governor's Commission on Home and Community-Based Services, its Task Forces, and the Consumer Advisory Committee have focused on the development and evaluation of a number of additional, but generally much more far-reaching actions. 28 new actions are now being presented; all of which are essential to create the basic infrastructure, improve processes, and/or provide the services and supports needed to provide quality community-based services cost-effectively, while significantly enriching the lives of frail seniors, persons with mental illness, persons with physical and/or developmental disabilities, and children at-risk.

The Commission selected four (4) broad categories for presentation of the twenty-eight (28) new actions. These include:

- Rebalancing the Long-Term Care System – This category includes ten (10) actions that are specifically targeted to those changes which will provide or build upon the community service infrastructure needed to support a large and growing consumer population.

- Removal of Barriers – This category includes eight (8) actions that specifically focus on removal of key obstacles to expanding or improving community-based care.

- Community Capacity – This category includes eight (8) actions that specifically focus on opportunities to build upon or improve the services and supports that must be in place for consumers to live safely and successfully in a community-based setting.

- Children at-Risk – This category includes two (2) actions that are specifically targeted to improve and/or expand upon the service delivery system for children who are at risk and their families.

All 28 actions are specifically described within this Chapter. Each is sorted by category and referenced according to the lead agency or office that has responsibility for evaluation and implementation. For an abbreviated summary of the Actions, please see the Master List of all 28 actions separated by category and presented at the end of the Executive Summary.

3.1 Category: Rebalancing the Long-Term Care System

The following ten (10) actions represent initiatives that are specifically targeted to those changes that will provide or build-upon the community service infrastructure needed to support a large and growing consumer population. Those agencies or offices identified as responsible for taking the lead include the Office of the Governor and the Indiana Family and Social Services Administration.

3.1.1 The following two (2) actions fall under the responsibility of the Office of the Governor

Problem: Like most other states, Indiana is experiencing a severe economic downturn, creating extreme funding deficiencies. As a result, funding for social service/public assistance programs is being carefully scrutinized in order to determine how best and where to target cost containment initiatives, all of which are expected to adversely impact consumers and public assistance providers. In seeming contrast, recent court actions, such as *Olmstead v. L.C.*, mandate that states develop initiatives and expand opportunities to provide consumers with real choice in the care and type of services available to meet his/her needs. Clearly, the objective is to shift the long-term care service delivery balance from traditional, institutional care to community-based care and allow consumers to age in place in the setting of his/her choice for as long as possible.

These two contrasting issues make it difficult for states to move forward with a long-term care vision. New initiatives that are anticipated to produce savings in the long-term, often require an initial funding investment that states are unable to afford in the current economic climate. As a result, long-term goals are compromised at the sake of short-term investments. Necessary policy and program changes, including some that are neither efficient nor effective, are delayed indefinitely.

Action: The Governor should direct the Indiana Family and Social Services Administration and other state agencies (i.e., the Department of Workforce Development, Housing, the Indiana Department of Transportation, and the Indiana State Department of Health) to aggressively pursue all Federal grant opportunities that will fund, in whole or in part, a shift in consumer services that will reflect consumer choice, independence, and quality of life and produce positive health outcomes and cost-effective policy initiatives.

Target Population. Those who would be affected by this change are all persons who are eligible for and receive public assistance.

Policy Outcomes. New Federal grant initiatives are expected to assist states in shifting the delivery of critical healthcare and housing services to its low-income, frail elderly, and disabled populations. Provider industries will change in response to consumer demand.

System Barriers. Funding for Federal grant initiatives may be limited in some way, requiring states to pick up a portion of the expense. This may be extremely difficult for states to do when experiencing severe budgetary constraints. Staffing new initiatives may also be difficult, when state staff is already dedicated to other projects and program initiatives. Time-consuming and costly computer system changes may be required.

Responsible Agency(ies) and Action Steps. The Office of the Governor, the Indiana Family and Social Services Administration, the Department of Workforce Development, Housing, the Indiana Department of Transportation, and the Indiana State Department of Health are responsible for researching, evaluating, and pursuing all grant initiatives and opportunities.

Action steps include:
- Research of current and new Federal grant initiatives.
- Evaluation of current and new grant initiatives current and new Federal grant initiatives.
- Coordination with other agencies and stakeholders as necessary.

- Development of written grant applications.
- Timely submission of grant application.
- Administration of grant awards.

Fiscal Impact. The cost of implementing this recommendation depends upon the Federal grant initiatives that are pursued. The state share will likely vary between no state investment, some/all administrative expense, and/or some/all service expense.

Targeted Completion Date. All grant opportunities should be researched and evaluated on a timely basis. Grant applications should be written and submitted on or prior to all published deadlines. Research of new and existing opportunities should be initiated immediately and should continue indefinitely.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of Federal grants for which Indiana is an active recipient.
- Increase in the number and scope of new community-based initiatives and program expansions.
- Increase in Federal funds for new community-based initiatives and program expansions.
- Verifiable compliance with the State's *Olmstead* Plan.

Problem: State, Federal, and local public assistance program policies that drive healthcare, housing, and other services are typically made with little or no consumer input. There is no formal mechanism, process, or consumer body that is regularly convened and relied upon to provide constructive input, education, and guidance to policymakers. As a result, critical consumer programs and services are heavily influenced by provider issues and government concerns, limitations, and priorities, which may not address the needs, values, and priorities of consumers.

Action: The Governor should create a cross-disability consumer advisory council to advise him, the Indiana Family and Social Services Administration and other state agencies on issues that facilitate continuing progress on the *Olmstead* plan implementation and the movement of services toward home and community-based care. The Governor should strongly consider reappointing the members of the Commission's Consumer Advisory Committee, since they represent all target populations and have demonstrated strong understanding of the issues and the ability to collaborate well together.

Target Population. Those who would be affected by this recommendation include consumers and advocates who represent persons who are frail and elderly, persons with physical and developmental disabilities, persons with mental illness and/or substance abuse, and children and their families who are at risk.

Policy Outcomes. Implementation of this recommendation will improve state policymaking by incorporating consumer input earlier and more accurately, thereby reducing the need for system re-evaluation and re-design. State compliance with its *Olmstead* goals and priorities will be achieved quicker and more effectively. Consumers will be given more "voice" in the programs and services upon which they depend. State and contract staff and providers will become more

aware of and knowledgeable of consumer needs, issues, and concerns, thereby improving the quality and delivery of publicly-funded services.

System Barriers. State and/or contract staff may be resistant to a consumer advisory process because of the number of stakeholder interests, boards, and other groups with and to whom they already must consult and/or respond. Consumer representatives may have transportation and mobility limitations that may impede their participation.

Responsible Agency(ies) and Action Steps. The Office of the Governor may establish this advisory council without administrative rule or state law. Action steps include:

- Appointment of members who represent all types of consumers in order to create a cross-disability forum.
- Designation of a council chairperson and/or state staff who will support the activities of the council.
- Identification of administrative resources that will fund the travel and meeting expenses of the members and the staff support.
- Development of a meeting protocol and feedback mechanism.
- Identification of mission statement, goals, and objectives.

Fiscal Impact. The cost of implementing this recommendation will consist of administrative expense associated with dedicated state staff time and travel time and expense of council members.

Targeted Completion Date. The council members should be appointed by September 30, 2003, with the first meeting scheduled before December 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Selection of dedicated, active Council members.
- The convening of regular and frequent meetings.
- Development of a full and meaningful agenda for those meetings.
- Decrease in the number and scope of project implementation and system and/or process modification errors.
- Improvement in consumer satisfaction with governmental services (typically documented through consumers surveys).

3.1.2 The following eight (8) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: Federal regulation mandates that Indiana's Medicaid Home and Community-Based Services Waiver for the Aged and Disabled specifically targets persons who are in need of nursing home care. Yet even though the target population is the same, the financial criteria for Medicaid Waiver Program services is much more restrictive than for nursing home services. Specifically, the income of persons eligible for the Medicaid Waiver is limited to 100% of the Supplemental Security Income (SSI) amount, or $552. This means that if the individual's income exceeds $552 in any given month, (s)he loses Medicaid eligibility for services and must spenddown his/her income to the 100% SSI amount to regain eligibility. In contrast, an individual who has income above the 100% SSI amount ($552 monthly) does not lose his/her Medicaid eligibility for nursing home services. Rather, the income that is above the 100% SSI amount (less a monthly $52 personal needs allowance) may be applied directly to the cost of the nursing home care, and the individual continues to be eligible for Medicaid. This creates an "institutional bias" where the individual's only real choice is nursing home care. In other words, only individuals who have monthly incomes of $552 or less are eligible for Medicaid Waiver services, but incomes of $552 or less are not enough to cover living expenses. As a result, this current, very stringent income standard established for the Medicaid Aged and Disabled Waiver denies many persons who are frail and elderly or physically disabled from receiving critical services in their own homes.

The 300% SSI standard has already been adopted for consumers who receive services through the Medicaid Developmental Disabilities and Support Services Waiver programs.

Action: Raise the monthly income eligibility standard for the Medicaid Aged and Disabled Waiver (and all other applicable waivers) to the federally-allowed limit of 300% (i.e., $1,656) of the Supplemental Security Income amount. This change will allow an individual to keep more of his/her income and still be eligible for Medicaid Waiver services. This recommendation is further supported by a similar provision included in Senate Bill 493 (2003).

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and persons with developmental disabilities who have overriding medical needs.

Policy Outcomes. The implementation of this recommendation will establish policy consistency and equality between all Medicaid Waiver programs and Medicaid-funded nursing home services. It will help to eliminate institutional bias and effectively eliminates Medicaid spenddown for most individuals already receiving services through the Medicaid Aged and Disabled Waiver. It will establish a balance in Indiana's long-term care service delivery system by allowing all nursing home eligible persons the choice of receiving services in a nursing home or in their own homes or other community setting. It is also important to note that this policy change has already been made to two of Indiana's Medicaid waivers that serve persons with developmental disabilities. Finally, the adoption of this policy change will remove a significant and long-

standing barrier in providing and expanding community services for persons who are frail and elderly or physically disabled.

System Barriers. There are a number of major barriers that can be expected to significantly limit the impact of this recommendation and significantly delay the opportunity to reach the target for achieving program savings. These barriers are as follows:

- Consumers are often admitted to nursing homes directly from hospitals as part of their Medicare treatment protocol. Therefore, it is critical that these consumers are included in a targeted outreach effort and informed in a timely manner about their options to return to the community.
- The ability to serve consumers in alternative community settings is dependent upon the availability of Medicaid Waiver providers; Medicaid Waiver providers in Indiana are currently very few in number.
- There is no standard method for establishing competitive reimbursement rates for Medicaid Waiver providers.
- Processing time for Medicaid Waiver applications is very lengthy.
- The existing quality assurance process is very limited and cannot accommodate significant expansion in the number of people served in the community. Significant policy and program modifications are required, as well as a significant increase in state and local quality assurance staff.
- Affordable and accessible housing in Indiana is extremely limited, making the institutional bias very difficult to overcome.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning, the Division of Family Resources, and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change. The action steps include: developing the written policy; calculating a comprehensive and accurate fiscal impact; identifying any state match funds that may be needed; training staff involved with eligibility determinations; developing and implementing a viable plan that will begin responding to and resolving the systems barriers described above; and presenting that policy to the Centers for Medicare and Medicaid Services in the form of a written Medicaid amendment to the Aged and Disabled Waiver. Further, it is critical that the Indiana Family and Social Services Administration identify and pursue opportunities to partner with the business and local public community to resolve some of the identified systems barriers.

Fiscal Impact. The Office of Medicaid Policy and Planning performed a comprehensive fiscal impact analysis that evaluated a number of specific cost and program factors, including the following:

- Average per-person Medicaid and other state-funded (i.e., the CHOICE program) costs for all Aged and Disabled Waiver consumers, including the distribution of costs (ranging from high to low);
- Average per-person Medicaid and other state-funded (i.e., the CHOICE program) costs for nursing home consumers, including the distribution of costs and the effect of CMI scores on reimbursement;
- Aggregate Aged and Disabled Waiver and nursing home costs;
- Medicaid spenddown and patient liability; and
- Total funded waiver costs, including both used and unused waiver slots.

Results of this analysis revealed an *immediate* annual and on-going fiscal impact of raising the monthly income standard from 100% to 300% of SSI to be $2.7 million in state funds. Implementation of this policy should, however, reduce administrative costs associated with calculation and oversight of monthly Medicaid spenddown amounts for persons who are currently, or would otherwise be in spenddown status and eligible for and receiving waiver services.

The analysis also evaluated the *longer-term* program and cost effect on nursing home census, payment rates, and nursing home resident acuity. Specifically, the purpose of raising the monthly income standard for the Medicaid Aged and Disabled Waiver from 100% to 300% SSI is to immediately allow more persons to be able to afford to remain in the community and receive the less expensive healthcare provided through the Medicaid Waiver. The effect of this shift in services will serve to simultaneously reduce the number of nursing home admissions. Therefore, as more persons are diverted from nursing home care, total waiver expenditures will increase and total nursing home expenditures will decrease. Moreover, nursing home services will be appropriately directed to residents with higher acuity, generating higher per person nursing home payment rates but lower total nursing home expenditures (because of a lower resident census). The analysis further revealed that the total savings in nursing home expenditures will begin to exceed the start-up costs of implementing this policy change once approximately 1,000 persons have been diverted from nursing home care. As more persons are diverted, more savings will be generated. Therefore, the sooner this policy change is implemented, the less start-up costs the State will incur and the sooner the shift in services and expenditures can be achieved.

Finally, the analysis identified at least thirty-four (34) states that utilize the 300% SSI policy for its Aged and Disabled Waivers.

Targeted Completion Date. The Transitions Task Force originally recommended that monthly income standard for the Medicaid Aged and Disabled Waiver should be raised to 300% SSI by no later than July 1, 2004. In order to mitigate the immediate start-up expense associated with this policy change, this may, however, be accomplished by implementing an incremental series of changes; i.e., from 100% to 200% and then from 200% to 300%, provided that the 300% standard is adopted by no later than July 1, 2004.

Senate Enrolled Act 493 (2003), however, mandates the increase to 300% SSI, with an effective date of July 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the number of Medicaid recipients having spenddown status.
- Decrease in the institutionalization rates of Medicaid recipients who meet institutional level of care criteria.
- Decrease in nursing home resident census state-wide.
- Decrease in the number of Medicaid-eligible nursing home readmissions.

Problem: Adult foster care is an essential service within the array of long-term care services, since it provides both necessary healthcare services and affordable and accessible housing in an intimate community residential setting. For these and other reasons, foster care is an absolutely vital component of the child welfare system, yet it has never been fully developed, either privately or publicly, as a service option for Indiana's residents who are frail elderly or who have physical disabilities. Adult foster care is generally defined in Indiana as any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. Services include: personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under State law).

Action: A targeted Medicaid Home and Community-Based Services Waiver for Adult Foster Care must be developed and implemented. This should be a new, separately funded Medicaid Waiver Program that is specifically targeted to build capacity in this service area.

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and developmentally disabled individuals who have overriding medical needs.

Policy Outcomes. The development of a new Medicaid Home and Community-Based Services Waiver for Adult Foster Care will complete the full array of service options necessary to provide cost-effective, community-based services to Indiana's low-income, elderly, and physically disabled residents. Adult foster care is a particularly important service option since it provides both healthcare and accessible and affordable housing, the latter of which is extremely limited in Indiana. This service will be available to persons who are nursing home eligible (as required by Federal law) but who prefer to receive services in a non-institutional community setting and for whom such services can be provided safely and cost-effectively. This service addition can be expected to provide a cost-effective community alternative to persons who may currently be excluded from other Medicaid Waiver Programs because their care is too costly to provide. A targeted Medicaid Waiver will allow an adult foster care provider base to be developed, and additional consumers to be served in a cost-effective, community setting.

System Barriers. Given the service and housing combination of adult foster care, a targeted quality assurance and monitoring protocol must be established and carefully maintained to ensure consumer safety, quality care, and provider compliance. Since Indiana does not recognize or license adult foster care services, provider training about Medicaid waivers (including, but not limited to, documentation and billing requirements) and service standards must be completed and carefully monitored. Specialized and frequent case management must occur to assure that the needs of adult foster care consumers are fully and continually met. Qualified state and/or contractor staff must be assigned to, and fully responsible for ensuring the safety and quality of life of consumers.

Computer system changes will be required and may be difficult or time-consuming to implement. State and/or contract staff will need to be dedicated to this service and fully trained.

Approval from the Centers for Medicare and Medicaid Services (CMS) is required in order to implement this new Waiver Program. Approval is not expected to be simple or quick, since a

number of states have failed Federal waiver audits of their adult foster care services due to poor quality of care, poor state oversight, and consumer safety issues. Therefore, it is reasonable to expect that CMS will scrutinize the quality assurance program for this new waiver.

State staff have been historically resistant to developing and administering another Medicaid Waiver Program.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for developing and implementing the new Adult Foster Care Waiver. The action steps include: developing the written policies; establishing provider certification standards; establishing a training curriculum for staff, consumers, and providers; establishing competitive reimbursement rates; identifying and implementing all necessary computer system changes; establishing a reliable quality assurance oversight and monitoring protocol; identifying new and dedicated state and/or contract staff to administer and oversee this service; and writing and submitting a waiver program application to the Centers for Medicare and Medicaid Services.

Fiscal Impact. Since this is a new Medicaid Waiver Program, new funding will be needed. The fiscal impact will be based on service utilization, and the design, development, administration, and oversight of the program. Additionally, the analysis should include a review of the short- and long-term effects of this program, including any projected savings that will occur over time. Implications for nursing home expenditures and resident census and acuity should also be considered. It is, however, essential to realize that failing to pursue adult foster care as a significant community care alternative has a cost as well; without this option, the lack of affordable, accessible housing will remain a significant barrier that severely limits the further development of community-based alternatives. It is precisely the adult foster care (and assisted living) service alternatives that provide the cost-effective combination of housing and services that allow consumers the option of safely remaining in the community to age in place for as long as possible. All states that offer extensive community-based programs depend heavily on both assisted living and adult foster care service programs.

Targeted Completion Date. The Indiana Family and Social Services Administration should develop a comprehensive fiscal impact analysis that consists of the following:

- The number of consumers to be served by the program, for each of the first two years;
- Detailed administrative costs related to program design and development (i.e., computer system; staffing; other);
- Expected service costs, including estimated provider rates, specialized case management, and direct state staff involvement; and
- Detailed administrative costs related to quality oversight and monitoring, including but not limited to: state and/or contractor staff; case management; long-term care ombudsman; program auditors; and adult protective services.

This fiscal impact analysis should be completed by no later than October 1, 2003.

As an accompaniment to the fiscal impact analysis, the Indiana Family and Social Services Administration must also complete a fully-developed implementation plan**,** that includes a detailed evaluation of a pilot program and a list of public/private cooperative opportunities that should be pursued. This shall also be due on October 1, 2003.

Finally, the new Medicaid Adult Foster Care Waiver should be implemented *as soon as possible but only after all funding has been identified and all action steps have been completed*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:.

- Implementation of a targeted Adult Foster Care Medicaid Waiver Program.
- Development of an adult foster care consumer base, with the number of consumers increasing each quarter.
- Development of an adult foster care provider base, with the number of providers increasing each quarter.
- Increase in the number of quality assurance staff assigned to the adult foster care program.
- Minimal incidences of consumer dissatisfaction, abuse, and neglect.
- Development of rigorous quality assurance standards and evidence of strong oversight and on-going monitoring.

Problem: Adult day services (adult day care) are an integral community healthcare option within the long-term care service delivery system. They provide a regular, daily care alternative for the frail elderly and persons with disabilities that allows them to receive care and social interaction while allowing their primary caregivers to continue working outside the home or to receive necessary respite.

There are two primary issues in Indiana that hinder the success of adult day services as a viable community care alternative. First, adult day services currently have a very limited capacity. There are only 68 adult day centers, located mostly in urban areas and fully serving only 26 counties[7]. According to national research conducted by the Robert Wood Johnson Foundation, Indiana needs 119 more centers to fully meet Indiana's service needs. Second, the adult day service centers that Indiana does have are significantly under-utilized (48%). This is due to a lack of clear information and understanding about adult day services by consumers and referral sources. This under-utilization makes it difficult to recruit and retain providers. Clearly, there is a disconnect between the availability of the services and the referral of consumers to the services since national statistics indicate that Indiana has multiple under-served populations.

Action: Adult day services should become a targeted service within Indiana's long-term care service delivery system, not only for consumers who receive public assistance, but also for consumers who are able to pay privately. The targeting effort should include: development of educational materials and outreach to consumers and referral sources that clarify adult day services; development of enhanced orientation and training for adult day services staff to help them meet the complex needs of a "sicker" participant base; and exploration of successful models of rural home and community-based service delivery models for potential replication (e.g., Administration On Aging Alzheimer demonstration grants).

Target Population. Those who would be affected by this change are adults (both private pay and those who depend upon public assistance) who are frail and elderly and/or physically, developmentally, or mentally disabled and their caregivers.

Policy Outcomes. Implementation of this recommendation will help to grow a provider industry that can be expected to contribute significantly to Indiana's array of community-based services. Adult day services provide a real non-institutional and cost-effective[8] alternative for elderly and disabled persons whose primary caregivers who are in need of respite or who work outside the home. With medical monitoring, and by supporting the caregivers, adult day services provide vulnerable individuals with greater opportunity to receive necessary care and have social interaction intermittently, and thereby age in place in their home setting.

System Barriers. Implementation of this recommendation will likely result in some resistance from providers to increased staff time in orientation and training. In addition, there is currently no established state-wide educational process that fully presents the array of adult day services available to consumers. Lack of affordable, accessible transportation can be a significant barrier, particularly in rural areas when the consumer does not have family members or others available to assist them. Additionally, the CHOICE and Medicaid Programs have little experience with this provider group, therefore state and local staff may be unprepared in understanding and overcoming policy limitations and developing necessary outreach and timely and efficient reimbursement processes.

Responsible Agency(ies) and Action Steps. The Bureau of Aging and IN-Home Services, the Bureau of Developmental Disabilities Services, and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change.

Action steps include:

- Development of a written marketing/development plan prepared by the adult day services trade association.
- Submission of that written plan to the Bureau of Aging and IN-Home Services for review and monitoring.
- Development of a written resource by the Bureau of Aging and IN-Home Services.
- Development of a state website dedicated to adult day services by the Bureau of Aging and IN-Home Services.
- Incorporation of adult day service description into regional and statewide training programs, including but not limited to: the Annual Governor's Conference on Aging; Area Agency on Aging training curricula for case managers and others; hospital discharge planning trainings; annual case management conference; nursing home associations' annual conferences; Indiana Medical Association curricula; and all service and information entry points for consumer.

Fiscal Impact. The administrative cost of implementing this recommendation is expected to be minimal, since this already falls under the administrative responsibilities assigned to the two bureaus. The cost implications of expanding adult day services within the CHOICE program and Medicaid Waiver Program should be budget-neutral in the short-term, since total funds are already allocated and this service will simply present another service option to consumers who have a limited budget. Savings are, however, possible in the longer-term since adult day services may delay or prevent an individual from seeking more costly nursing home and hospital services.

Targeted Completion Date. This initiative should be incorporated into existing training modules and consumer and provider outreach materials. Full implementation should occur no later than January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of adult day service providers.
- Increase in the number of consumers who utilize adult day services.
- Increase in the overall utilization of adult day service providers.
- Decrease in institutionalization rates for consumers of adult day services.
- Decrease in acute care expenditures for consumers of adult day services.

Problem: The Indiana Medicaid Program's nursing home expenditures (approximately $800 million annually) continue to be significantly higher than other states (77% of all long-term care expenditures, compared to 57% nationally[9]). In contrast, Indiana's Medicaid Home and Community-Based Services Waiver Program expenditures total approximately $277 million[10]. In order to balance long-term care expenditures to better accommodate consumer choice in care and service delivery, Indiana must implement a diversion process that presents consumers with real alternatives to nursing home placement and/or supports them during a short stay in the nursing home for rehabilitation.

Indiana has been working toward this goal for a year. Even though there is progress, as of June 6, 2003, out of a goal of 1,000, there have been only 219[11] persons who have been successfully diverted. This slow progress can be attributed to a number of administrative and other barriers that include the following:

1.) Hospital discharge planners and social service designees are responsible for efficiently and expeditiously discharging hospital patients. They are familiar with nursing home level of care criteria and are generally able to transfer patients who are nursing home-eligible quickly and safely; they are not paid or assigned the responsibility to pursue the State's goal of diverting consumers from institutional care and doing an at-home evaluation or performing a case conference with the family.

2.) Nursing home social service designees face similar barriers; i.e., lack of training, lack of priority by management, and demands to keep beds filled.

Action: State and/or contractor staff must be integrated into the nursing home discharge process to ensure that consumers who can remain in their own homes/community setting can receive necessary services and/or support and monitor consumers who are placed in nursing homes for temporary care to ensure that they are successfully transitioned back into their own home or alternative community setting of their choice.

Target Population. Those persons who will be affected by this change are all acute care hospital and nursing home patients who are in the process of being discharged and who meeting nursing home level of care criteria.

Policy Outcomes. Implementation of this change will allow consumers the opportunity to understand their care choices, make informed choices, and receive on-going case management to support and monitor the care received. Undesirable institutionalization may be averted, thereby improving the consumer's opportunity to age in place in the setting of his/her choice, and

improving quality of life. Additional acute care episodes may be minimized and undesired institutionalization delayed or avoided altogether.

System Barriers. The barriers to implementing this action are as follows:

- If the state discontinues funding the regular Medicaid Aged and Disabled Waiver Program slots, there will be even fewer community service alternatives available for consumers who wish to avoid nursing home placement.
- The present system does not distinguish between an individual placed in a nursing home for rehabilitative services and one who needs rehabilitative services and then assistance in returning home. Without a case manager follow-up within the 100 days of nursing home care covered by the Federal Medicare Program, these individuals tend to remain in the nursing home indefinitely.
- There is an insufficient number of case managers available to follow the consumer to nursing home and facilitate transition back to the home or other community setting.
- Hospital discharge planning staff may not be able to assist with the additional responsibilities associated with a diversion initiative unless there is a financial incentive and/or legislation, rule, or other mandate that requires their participation.
- Individuals working within institutional settings (like acute care hospitals and nursing homes) may be uninformed about available community care service options and about the very different quality standards that apply to non-institutional settings.
- Legislation, rules, and/or mandates may prevent necessary access of the area agency on aging diversion staff to information related to the hospital discharge.
- Staff time to assess clients that choose to go to the nursing home or who do not qualify.
- It has not been determined how best to identify individuals that will have the potential of returning home after rehabilitation.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitative Services within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- Evaluation of successful program models used in other states (e.g., Illinois and Washington). The model should include universal pre-screening and funding for case managers employed by the State and/or its contractors to follow the consumer into the nursing facility.
- Completion of a fiscal impact analysis to determine the full administrative cost of implementing this diversion process.
- Development of policies, rules, and/or legislation needed to implement this recommendation.
- Development of simple, clear, and concise education and marketing tools, the target of whom will be hospital discharge planners, doctors, and nursing facilities.
- Define the process as a Universal Screening Process that encompasses nursing home placement, home and community-based services (the CHOICE program, Medicaid and private pay), and/or the opportunity to refuse all services.

The Universal Screening Process shall:

- Educate individuals at risk of nursing facility placement[12] and their families/caregivers about options for long-term care.
- Result in an improved quality of life and care for individuals by giving them the choice to receive care based on a person-centered plan.

- Reduce inappropriate nursing facility placement.

The process must include maximum of time to complete each step. For example, Illinois' time frames are:

- Universal Prescreening – within two (2) calendar days of referrals (date of referral is not counted as a day); perform this with a caregiver/family conference whenever possible.
- Case management follow-ups – in place within two (2) working days from the date of notification.
- Follow-up visit by the case manager after nursing facility placement – within 60 calendar days of placement.
- Post screening – completed within fifteen (15) calendar days of request.

Fiscal Impact. A fiscal impact analysis will need to be completed that includes adequate funds for staff and administrative functions such as marketing and educational funds. A staffing standard should be adopted; e.g., one FTE (full time equivalent) for every 60 attempted and 20 successful diversions. This program will be new, so further evaluation of the staff time needed to implement this program is also required.

Targeted Completion Date. A comprehensive fiscal impact analysis should be completed by September 30, 2003. This analysis should be accompanied by an implementation that includes potential funding source and a full phase-in plan. Rules should be pursued as soon as funds are identified; or if legislation is required, it should be pursued during the 2004 legislative session. This recommendation should be implemented beginning on July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the institutionalization rates for persons who meet institutional level of care criteria.
- Decrease in the utilization of acute care services for the same population.

Problem: In order to participate in the Medicaid Program, State Medicaid Agencies are required to fund institutional care for its beneficiaries, while community-based funds are not required. Similarly, other state and Federal public assistance programs establish criteria that limit funding in some way, often to the fiscal detriment of the State and the physical detriment of the consumer. The effect of these policies is to sustain a long-standing bias that favors institutional services over community-based services, even when the institutional services are more expensive and less desirable.

Action: Funding for public assistance programs should be transparent to the consumer and should follow the consumer to the service setting of his/her choice. This principle has been embodied within Senate Enrolled Act 493 (2003 Indiana General Assembly).

Target Population. Those who would be affected by this change are all low-income persons who are elderly, persons with disabilities, and person with mental illness who are eligible for and/or who receive public assistance.

Policy Outcomes. Implementation of this recommendation will allow for a greater number of Indiana's consumers to be served in cost-effective, community settings that reflect his/her choice in healthcare services. Providers will need to compete for consumers, thereby improving quality of care and consumer health outcomes. State program expenditures will need to be carefully monitored to ensure budgetary compliance. Resident census in institutional facilities (i.e., nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled; state hospitals) will decrease, while the acuity of the residents and the average facility reimbursement rates will increase. Similarly, the number of persons served in the community will increase, and it is likely that the acuity of those persons and the average cost of serving them in the community will also increase.

System Barriers. There will be a negative fiscal and economic impact on institutional providers, many of whom may appeal to the State and to the Legislature for relief. There may not be enough community-based services providers available to meet the needs of a growing consumer population. Quality assurance programs will need to be expanded in response to the growing shift of consumers away from institutional care and toward community-based care. Budget analysis and expenditure monitoring will be targeted to the expected and unanticipated effects of the policy change. There also needs to be consideration about how money is transferred when consumers leave one agency to begin services with another.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration and the State Budget Agency are responsible for implementing this policy change.

Action steps include:

- Review and evaluation of the administrative and funding limitations involved with the current fiscal administration of public assistance programs and this Action
- Review and evaluation of the projected economic effects on the institutional and community-based providers.
- Development of an implementation plan.

Fiscal Impact. The cost of implementing this depends upon the approach taken by the State. If existing funding is maintained and capped, then there would be no fiscal impact to the public assistance programs to implement this change. In contrast, however, the negative fiscal and economic impact on institutional providers is likely to be dramatic since more consumers are likely to choose community-based care if given the means to do so. If program funding is not capped or otherwise limited in some way, then there will be an undetermined increase in expenditures created by the addition into the public assistance system of new consumers (Woodwork Effect) who otherwise would have remained outside the system.

Targeted Completion Date. A comprehensive budgetary analysis should be developed by December 1, 2003. The change in administrative policy should occur on or before July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in resident census in institutional settings.
- Increase in the acuity of residents and the average reimbursement rate in institutional settings.
- Decrease in total institutional expenditures.
- Increase in the number of persons served by the Medicaid Waiver Program.

Problem: The Indiana Medicaid Home and Community-Based Services Assisted Living Waiver has been funded since July 1, 2001. Nevertheless, there are currently very few providers participating in the Waiver Program, despite available and dedicated funding. This problem is due to lack of dedicated state staff to develop the program (i.e., recruit providers; provide educational outreach and training, etc.), low or confusing reimbursement rates, administrative burdens and unfamiliar processes for small facility staff, and a lack of clear information and training for prospective providers.

Action: The Indiana Family and Social Services Administration must dedicate and charge staff to fully and immediately develop the Medicaid Home and Community-Based Services Waiver for Assisted Living. Efforts must focus on recruiting and enrolling assisted living providers and developing a compatible consumer base.

Target Population. Those who will be targeted in this policy directive are assisted living providers who are licensed in Indiana as a residential care facility and who qualify to participate in the Medicaid Waiver for Assisted Living. Those who will be affected by this initiative are certain low-income adults who are frail and elderly and/or disabled, and who meet nursing home eligible criteria, including: adults age 65 and over; adults with physical disabilities; and adults with developmental disabilities who have overriding medical needs.

Policy Outcomes. Evaluation and dedicated development of this Medicaid Waiver Program should result in the following: a significant increase in participating providers and consumers; an established program and administrative framework; good data collection; thorough and reliable quality monitoring and oversight; successful delivery of assisted living services; and a solid, interactive, and responsive partnership between assisted living providers and State Medicaid Waiver staff.

System Barriers. Difficulties associated with implementing this Action include: no dedicated state and local staff to communicate, design, modify, and develop a viable assisted living model; no current provider success to determine where policy changes are needed; poor information and provider training; lack of state understanding about the need for and value of a viable assisted living program; and communication and leadership problems associated with recent staff changes within the Indiana Family and Social Services Administration.

Responsible Agency(ies) and Action Steps. The Bureau of Aging and IN-Home Services and the Office of Medicaid Policy and Planning are responsible for implementing these initiatives. They must partner with the assisted living providers through the provider trade associations and the area agencies on aging.

The Bureau of Aging and IN-Home Services should provide a thorough, written plan for promoting and fully developing the Medicaid Assisted Living Waiver Program. It should include action steps that focus on building an assisted living provider base and must include, at a minimum:

- Streamlining the reimbursement methodology to include two or three reimbursement levels that directly relate to the levels of care currently permitted by residential care facility regulations.

- Developing a "pilot program" with one or two assisted living providers to modify the program, making it more user-friendly for providers and working out any challenges with the reporting/reimbursement process.
- Developing information that is brief and simple for providers who are new to the Medicaid System.
- Providing introductory seminars for interested providers.
- Providing educational training for providers who want to participate in the Medicaid Waiver Program.
- Establish a rapport and communication process with the area agencies on aging and the providers.
- Modify Medicaid financial eligibility policy to allow Medicaid spenddown to be treated as patient liability. Medicaid spenddown is a confusing and complicated process that would be replaced by a policy whereby the Medicaid Assisted Living Waiver resident pays her/his income liability directly to the provider; then Medicaid pays the difference.
- Developing and/or modifying the federally-required waiver program quality assurance protocol that complements the Indiana State Department of Health in its regulatory role for licensed residential care facility providers and meets the specific, individual needs of consumers who are served through this Medicaid Waiver Program.

The written plan should also include time-lines for program design, modification, and re-implementation, including the number and time-lines of consumers served.

Fiscal Impact. There should be no fiscal impact since the Medicaid Assisted Living Waiver was fully funded as a new program beginning in state fiscal year 2002 and included both administrative/staffing costs and service costs. There is, however, concern that the unused funding has been transferred elsewhere or reverted and that on-going funding may no longer exist.

Targeted Completion Date. Since this program is fully funded, this initiative should begin immediately. The written plan should be presented to the Commission by no later than December 1, 2003 with full implementation of the written plan beginning immediately thereafter.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Dramatic and continuous increase in the number of persons served by this Waiver.
- Dramatic and continuous increase in the number of participating assisted living providers.
- Decrease in institutionalization rates for persons served by this Waiver
- Decrease in utilization of acute care services by persons served by this Waiver

Problem: The Medicaid Home and Community-Based Services Waiver application and approval process is very complicated and time-consuming. By necessity, it includes two separate determinations: one for general Medicaid Program eligibility (which includes financial and, in some cases medical disability determination) with shared responsibility between the county office of Family and Children and the Office of Medicaid Policy and Planning; and the other for determining Medicaid Waiver Program eligibility (which includes level of care and plan of care/cost comparison budget), the responsibility of which is shared between the local area agency on aging, the Office of Medicaid Policy and Planning, and the Division of Disability, Aging and Rehabilitative Services. Although there are no time requirements for determining Medicaid Waiver Program eligibility, Federal regulation requires general Medicaid Program eligibility for individuals applying for Medicaid disability to be determined within 90 days from the date of the individual's application for Medicaid, and for other populations to be determined within 45 days from the date of application[13]. For many reasons, determining Medicaid eligibility more quickly is difficult to achieve.

Action: The Indiana Family and Social Services Administration should establish a centralized Medicaid financial eligibility determination unit that is dedicated to Medicaid Waiver Program applicants. The purpose of this administrative change is to expedite the approval process for Medicaid Waiver applicants so that undesired institutionalizations may be avoided, and consumers are given the opportunity to receive services in their own homes and/or other community setting and to age in place for as long as possible.

Target Population. Those who would be affected by this change are all persons who apply for Medicaid Home and Community-Based Services Waiver Programs.

Policy Outcomes. Implementation of this change will create administrative efficiencies in processing time, training, and information sharing. Those administrative efficiencies are expected to create more timely determinations of Medicaid program eligibility, thereby allowing necessary services to be provided more quickly. This change will reduce the likelihood that consumers who prefer home care will need to be institutionalized unnecessarily. Improvements in the administrative process can also be expected to positively impact Medicaid Waiver providers by reducing the time between when services are arranged and when they can be initiated (and paid).

System Barriers. There are a number of administrative process and computer system changes that are required. State resources may be limited, as well as dedicated space to house the centralized staff and function.

Responsible Agency(ies) and Action Steps. The Division of Family Resources and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- The Division of Family Resources must request approval of necessary staff by the Human Resources Division and State Personnel (Done).
- The Division of Family Resources must recruit, hire, and train staff (It may be necessary for staff to be phased-in over a period of time.).

- The Division of Family Resources and the Office of Medicaid Policy and Planning must identify space in the Central Office for staff.

Fiscal Impact. A fiscal impact analysis has already been completed by the Division of Family Resources as part of the request for approval.

Targeted Completion Date. This policy change should be implemented by December 31, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in processing time for Medicaid waiver applicants.
- Decrease in institutionalization rates for persons who meeting institutional level of care criteria.
- Decrease in institutionalization rates for persons receiving Medicaid waiver services.
- Increase in the number of participating waiver providers.

Problem: Adult foster care is a vital service within the array of long-term care services, yet it has not been fully developed, either privately or publicly, as a service option in Indiana. Adult foster care is generally defined in Indiana as any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. Services include: personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under State law).

This option is already available, although not well-developed or highly utilized, through two of Indiana's Medicaid Home and Community-Based Services Waivers for persons with developmental disabilities.

Action: Adult foster care should be added as a service component to Indiana's Medicaid Home and Community-Based Services Waiver for the Aged and Disabled.

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and developmentally disabled individuals who have overriding medical needs.

Policy Outcomes. The addition of this service to the Medicaid Aged and Disabled Waiver will expand the full array of service options available to persons served by this waiver program. Adult foster care is a particularly important service option since it provides both healthcare and accessible and affordable housing, the latter of which is extremely limited in Indiana. This service will be available to persons who are nursing home eligible (as required by Federal law) but who prefer to receive services in a non-institutional community setting and for whom such services can be provided safely and cost-effectively. This service addition can be expected to provide a cost-effective community alternative to persons who may currently be excluded from the Medicaid Waiver Program because their care in a home setting is too costly to provide.

Utilization of the adult foster care service within the Medicaid Aged and Disabled Waiver is expected to be low, since the Medicaid Aged and Disabled Waiver primarily serves persons who receive care in their own homes, rather than persons who are seeking adult foster care.

System Barriers. Given the service and housing combination of adult foster care, a targeted quality assurance and monitoring protocol must be established and carefully maintained to ensure consumer safety, quality care, and provider compliance. Provider training and service standards must be established and carefully monitored; and specialized and frequent case management must occur. Qualified state and/or contractor staff must be assigned to, and fully responsible for ensuring the safety and quality of life of consumers.

Computer system changes will be required and may be difficult or time-consuming to implement. State and/or contracted quality assurance staff will need to be dedicated to this service and fully trained.

Finally, approval from the Centers for Medicare and Medicaid Services (CMS) is required to add this service to the Medicaid Aged and Disabled Waiver. This approval may not be simple or quick, since a number of states have failed waiver audits of their adult foster care services due to poor quality of care, poor state oversight, and consumer safety issues. Therefore, it is reasonable to expect that CMS will scrutinize the quality assurance program for this service.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning, and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for developing and implementing the new adult foster care service within the Medicaid Aged and Disabled Waiver. The action steps include: developing the written policies; establishing provider certification standards; establishing a training curriculum for staff, consumers, and providers; establishing competitive reimbursement rates; identifying and implementing all necessary computer system changes; establishing a reliable quality assurance oversight and monitoring protocol; identifying dedicated state staff to administer and oversee this service; and writing and submitting a waiver program amendment to the Centers for Medicare and Medicaid Services.

Fiscal Impact. There is no fiscal impact associated with the addition of the adult foster care service to the Aged and Disabled waiver, since the Medicaid Waiver Program budget and the number of persons receiving services is fixed for each year. There may, however, be some additional administrative costs associated with the development, implementation, and on-going quality monitoring of the adult foster care service.

Targeted Completion Date. The Indiana Family and Social Services Administration has already submitted the Medicaid Waiver Amendment to the Centers for Medicare and Medicaid Services and is currently awaiting approval. Nevertheless, in order to assure consumer safety and program success, the adult foster care service should be implemented *only after all action steps have been completed and by no later than October 1, 2003*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons receiving adult foster care services through the Medicaid Home and Community-Based Services Waiver for the Aged and Disabled.
- Increase in the number of participating adult foster care providers for same.
- Decrease in institutionalization rates for persons served on the Waiver.

- Decrease in acute care service utilization for persons served on the Waiver.

3.2 Category: Removal of Barriers

The following eight (8) actions represent initiatives that specifically focus on removal of key obstacles to expanding or improving community-based care. Those agencies or offices identified as responsible for taking the lead include the Indiana Family and Social Services Administration and the Indiana Department of Workforce Development.

3.2.1 The following seven (7) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: The Medicaid Home and Community-Based Services Waiver Program application and approval process is very complicated and time-consuming. Medicaid-eligible consumers throughout Indiana who apply for any of the Medicaid Waiver Programs often must wait months for their eligibility to be determined and approval of the individual care plan and budget[14]. Since Medicaid Waiver services cannot be provided until that approval is received (this includes approval of plan of care/cost comparison budget as well as Medicaid financial eligibility and level of care), Medicaid waiver applicants may experience deterioration in their condition and/or be institutionalized because they can no longer wait for the needed assistance to be provided in the community.

Action: The Indiana Family and Social Services Administration should immediately evaluate and implement administrative process changes that will streamline and significantly reduce the time involved in determining Medicaid Waiver Program eligibility (focusing on development and approval of the individual plan of care/cost comparison budget and the level of care entry) and initiating services to no more than 20 days. The Agency should also implement a pilot program with the Medicaid Aged and Disabled Waiver that will transfer the daily management (other than the negotiation of rates and payment of vendors) of the program to the local level in order to reduce processing time. This pilot should be carefully designed, monitored, and evaluated to determine whether state-wide implementation is desirable and feasible. It shall include: local approval of the individual care plan and budget; and local monitoring and quality assurance of waiver providers. (Please note that this Action does not intend for local monitoring and quality assurance to replace the federally-required quality, fiscal, and other oversight for which the Indiana Family and Social Services Administration is responsible.)

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and persons with developmental disabilities who have overriding medical needs.

Policy Outcomes. Implementation of this Action should reduce the time it takes to complete the waiver approval process to no more than 20 days and allow consumers to access needed services. Examples of possible opportunities for improvement include: paperwork that is transferred multiple times between the same process points; the requirement of up-front, written doctor

approvals which are necessary but extremely time-consuming to obtain; and collection of detail on the cost comparison budget that is very difficult and time-consuming to develop.

With respect to the pilot program, clear outcome measures should be determined prior to the start of the pilot program. The pilot model needs to be established so that if it is successful, it can be replicated in a consistent manner across the State.

System Barriers. Administrative system barriers may include Medicaid and other computer system changes, and approval by the Centers for Medicare and Medicaid Services (CMS). At this time, the Office of Medicaid Policy and Planning does not support expansion of the pilot to authorize the local administrative unit to manage the waiver payment process for several reasons, including but not limited to: lack of consistency in rate structures or how rates are determined locally and widely varying rates for Medicaid waiver services and rates paid locally for similar services under Indiana's CHOICE program. These differences must be evaluated and resolved prior to any consideration of feasibility for a local administrative unit pilot of rate payment for waiver services.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this pilot. Action steps include:

- Evaluating the Medicaid Waiver approval process and identifying opportunities for efficiency.
- If necessary, reviewing best practices of other states that have short application and approval processes.
- Training state staff and contractors on the process changes that will be made.
- Designing necessary computer system changes.
- Implementing all changes consistently and effectively.
- Establishing a comprehensive monitoring tool that will allow state and/or contract staff to identify the effects and overall success of the process modifications, and make any necessary adjustments quickly.
- Automation of level of care data entry process (between InSite and IndianaAIM); this has already been initiated.

For the pilot program:

- Identification of two local administrative units, one urban and one rural;
- Development of standards to measure the capacity of local agencies to administer the Medicaid Waiver Program locally;
- Evaluation of the accuracy of the software called InSite;
- Evaluation of the differences between the Medicaid Aged and Disabled Waiver and the CHOICE program (e.g., why do care plans from clients moved from the CHOICE program to the Medicaid Waiver increase);
- Evaluation of when it is not cost-effective to transfer a client from the CHOICE program to the Medicaid Waiver; and
- Development of a policy structure for local administrative units that will assure coordination with other agencies, such as the Bureau of Developmental Disabilities Services and independent case managers.

- Development of an outcomes measurement tool to evaluate the progress of the pilot to quantify any positive change and to assist in determining process improvements and state-wide applicability.

Fiscal Impact. The fiscal impact will consist of any computer and other administrative system changes associated with streamlining the approval process, and monitoring the pilot program.

Targeted Completion Date. Processing time for the Medicaid Waiver approval process should be modified and significantly reduced (by at least 50%) by no later than January 1, 2004 and by another 50% by December 31, 2004. Processing time should be reduced to 20 or fewer days by April 1, 2005. The pilot program should be designed and implemented by July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the period of time that eligible Medicaid waiver consumers must wait for services to be initiated.
- Decrease in the amount of time that Medicaid waiver providers receive payment.
- Increase in the number of participating Medicaid waiver providers.

Problem: Medicaid Home and Community-Based Services Waiver providers are not authorized to begin delivering services until a number of administrative steps have been completed. This administrative process is unnecessarily time-consuming and complicated, resulting in a significant delay between when Medicaid-eligible consumers are determined to be eligible for the waiver and the date that case managers are notified electronically that services may be initiated. The delay is often so great that some waiver providers are no longer available to serve the consumer when the waiver approval is finally received, or they decline to accept new waiver clients altogether. As a result, consumers may no longer be able to wait to receive the necessary care in the community, so they are unnecessarily institutionalized because nursing home services can be approved much quicker.

Action: The Medicaid Waiver approval process should be modified to allow the cost comparison budget that is developed locally and early on in the approval process to serve as the initial waiver plan of care. This approach is the same as that used in determining institutional eligibility and will reduce the time involved in the waiver approval process significantly. In addition, it will allow waiver providers to initiate and be paid for services much earlier (at the time that the cost comparison is developed). This approach has already been implemented successfully for the preadmission screening process with an error rate of less than 1% out of 4,000 decisions made locally[15].

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet institutional eligibility criteria, including: adults age 65 and over; and physically and/or developmentally disabled individuals of any age.

Policy Outcomes. The implementation of this Action will allow Medicaid Waiver services to be initiated more quickly, thereby allowing more consumers to receive necessary care in the community setting of their choice with more providers willing to provide that care. It will help to eliminate institutional bias by allowing services to be arranged for and provided more quickly to consumers. Similarly, it will also assist in building the waiver provider base by allowing services

to be provided soon after the service plan is developed and by assuring more timely reimbursement.

System Barriers. There may be administrative or process obstacles involved with modification of the existing process, and there may be concerns that state staff have with accepting the cost comparison developed locally as the initial plan of care and the trigger for reimbursement. Historically, state staff have made a more restrictive interpretation of a Federal limitation that reimbursement can not be initiated prior to the approval of the initial plan of care.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change. The action steps include: developing the written policy; modifying any necessary intake forms, modifying computer systems, training state staff about the process changes, developing informational outreach for consumers and providers, and requesting approval for the policy change to the Centers for Medicare and Medicaid Services in the form of a written Medicaid amendment to the Aged and Disabled Waiver.

Fiscal Impact. There is no administrative expense associated with this change. There may, however, be some administrative savings associated with increased efficiency in processing; i.e., fewer action steps for obtaining approval.

Targeted Completion Date. This policy change should be implemented by no later than July 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the period of time that eligible Medicaid waiver consumers must wait for services to be initiated.
- Decrease in the amount of time that Medicaid waiver providers receive payment.
- Increase in the number of participating Medicaid waiver providers.

Problem: Individuals with mental illness who are admitted to a state hospital are dis-enrolled from the Indiana Medicaid Program during their period of hospitalization because of limitations within the State's computer systems. The systems-related difficulties occur because Federal Medicaid regulation prohibits coverage of the hospital service, therefore states are responsible for paying the full costs. So, even though an individual does not lose his/her eligibility for Medicaid, his/her eligibility becomes temporarily "suspended" during the period of hospitalization in order to accommodate the shift in payment responsibility from Medicaid to the State. Similarly, children who are 18 – 21 and who age out of foster care often lose their Medicaid benefits unnecessarily because the case is not appropriately transferred to the new Medicaid category. When this dis-enrollment from Medicaid occurs, individuals who are discharged from the state hospital into the community and children who age out of foster care must wait an extended period of time for benefits to be re-instated. During that period, the individuals are denied vital pharmaceutical, treatment, and other healthcare services that are essential for successful transition (and sometimes even basic survival) into the community.

Unlike Medicaid, Federal law requires an individual's eligibility for Social Security benefits to be discontinued[16] during the period of institutionalization in a state hospital. To ensure successful transition back into the community, Federal law/regulation authorizes states to process the eligibility re-determination prior to the individual's discharge from the institution in order to ensure that benefits are available immediately upon the individual's discharge. Despite this Federal authorization, however, Indiana does not have a mechanism/policy in place to re-determine eligibility prior to discharge so that it coincides with an individual's discharge. As a result, the individual is denied the monetary assistance (to which (s)he is entitled) that is absolutely essential for covering basic housing, food, and other expenses.

Action: State eligibility policy and/or administrative process for Medicaid and Social Security benefits should be modified to ensure that there is no lapse in coverage when a consumer transitions from an institution into the community or when a child ages out of foster care. There should also be developed an expedited process for persons who were not on Medicaid and/or who did not receive Social Security benefits at the time of admission to the state hospital to apply for and become approved for Medicaid and Social Security (when all eligibility requirements are met) prior to discharge in order to ensure that both Medicaid and Social Security benefits are available to the individual immediately upon discharge.

Target Population. Those who would be affected by this change are all adults age 18 to 64 with serious mental illness who are admitted to a state mental hospital and who are eligible for Indiana Medicaid and/or Social Security benefits and all children ages 18-21 who age out of foster care.

Policy Outcomes. Implementation of this Action will provide a very fragile, at risk population (499 adults with mental illness during SFY 2002[17]) with the basic supports needed to survive and eventually succeed in, the transition from a state hospital to the community. This policy change will significantly and positively impact health outcomes, as well as mortality rates among this population. In short, implementation of this policy Action restores or expedites eligibility for two programs to which many individuals are entitled, but does so in a timely manner. The same is true for children who age out of foster care and who need continued Medicaid assistance.

System Barriers. Since both Medicaid and the Social Security eligibility determination process are operated as joint Federal/state programs that are administered according to each state's unique characteristics, laws, and regulations, program eligibility and administrative policies are not always consistently interpreted and applied among or even within states. Critical Medicaid and Social Security benefits that are not available during an inpatient hospital stay are often dropped during the hospital stay, either deliberately or unintentionally, making reinstatement of benefits unnecessarily burdensome and time-consuming. System changes may be required and may be complex to implement. Communication among state staff is poor, and care coordination for persons who are transitioning from an institutional back into the community is inadequate or non-existent. Previous housing arrangements may be lost, and may require extensive and time-consuming efforts to restore or identify new. Similarly, life-sustaining food and personal care items may not be accessible to consumers without the income received through the Social Security benefit. Consumers who depend upon essential drug and treatment protocols established prior to hospital discharge may experience serious and even life-threatening setbacks that reduce the likelihood of successful transition back to the community.

Responsible Agency(ies) and Action Steps. The Division of Mental Health and Addictions, the Division of Family Resources, the Office of Medicaid Policy and Planning, and the Disability Determination Bureau within the Indiana Family and Social Services Administration are responsible for evaluating and implementing this change.

Action steps include:

- Review and evaluation of existing policy.
- Determination of administrative and systems changes that are needed to implement the policy change.
- Development of an implementation plan with time-lines.
- Training of state staff.
- Implementation of a real-time quality assurance protocol to verify reinstated coverage/intended outcomes prior to and immediately after hospital discharge.

Fiscal Impact. The administrative cost of implementing this Action is expected to be minimal. There can, however, be expected a significant cost savings to the State related to decreased lengths of stays and decreased incidences of re-institutionalization in state hospitals, which are as prescribed by Federal law, paid with 100% state funds. Cost savings can also be expected by: providing preventive services that ameliorate the incidences of emergency room visits/acute care treatments; fewer and more efficient and effective case management services; and less expensive treatment and drug regimens that occur when consumer health status is stabilized.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than October 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Verification that all Medicaid and Social Security beneficiaries are able to access services immediately upon discharge from a state hospital
- Decrease in the number of state hospital readmissions
- Increase in utilization of community-based services for Medicaid-eligible consumers immediately upon and for six months after discharge from a state hospital

Problem: Indiana does not have an enduring infrastructure to nurture and support consumer-directed personal assistance services.

Action 10: The Indiana Family and Social Services Administration must develop the infrastructure for a consumer-directed care program. At a minimum, this infrastructure shall include:

1.) Policies and procedures to implement fiscal intermediary services to support consumer- directed care that are standardized and available throughout Indiana. It must include sufficient start-up money to ensure an adequate cash flow.

2.) An easily accessible single source of information and education for consumers and their employees, caseworkers and providers regarding how to implement and sustain the provision of consumer-directed care

3.) A marketing plan that includes the publication of user-friendly information regarding the availability of consumer-directed services and the advantages and disadvantages of directing the individual's own care.

4.) A standardized training curriculum for all case managers in Indiana providing services to consumers eligible for consumer-directed care services and supports with training done within six months of implementation of the program. Training and educational opportunities should be offered at least semi-annually.

5.) A menu of standardized training and educational options to support the decision to access consumer-directed services and supports for all consumers and their employees. This should be done within 30 days of indicating an interest in the program.

6.) A statewide strategy, including the encouragement of public and private partner-ships, for increased recruitment, retention and training of individuals willing to provide services and supports to persons with disabilities.

Target Population. Consumers affected by this change include persons who are frail and elderly and/or with disabilities, who want to direct their own care in their own homes and in their own communities. Other persons who are affected by this change include persons already employed by consumers and persons who support the individual choices of consumers with disabilities and may be interested in becoming a personal care giver.

Policy Outcomes. Implementation of this Action can be expected to grow, the number of persons willing to become personal care attendants, as well as improve the employment retention rates for persons who already serve as personal care attendants. This increase in provider capacity will directly and positively impact consumers by introducing and/or extending the opportunity to remain in the community, decreasing unwanted institutionalizations (thereby further diminishing the longstanding institutional program and fiscal biases), increasing choice among available providers, and enhancing quality of life.

Responsible Agency(ies) and Action Steps: The Indiana Family and Social Services Administration is responsible for implementing this Action .

Fiscal Impact. The fiscal impact is unknown until many of the action steps are completed. It is, however, important to determine both the short-term costs and the long-term costs and implications, since enhancement of the personal care provider pool can be reasonably expected

decrease institutional (both acute care hospital and nursing home) costs, thereby generating possibly significant savings over time.

Targeted Completion Date. January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Development of a consumer base for participation in consumer-directed care with growth documented quarterly
- Development of a personal care attendant base for participation in consumer-directed care with growth documented quarterly
- Increase in retention time for personal care attendants
- Improved consumer satisfaction as documented through consumer surveys, provider retention, etc.
- Decrease in the institutionalization rate for the Medicaid Waiver population

Problem: Indiana's Residential Care Assistance Program (RCAP) assists persons who are elderly and/or who have mental illness in obtaining and funding safe and affordable housing[18]. This funding is, however, not flexible and requires consumers to obtain housing from only those providers who participate in the State's Room and Board Assistance (RBA) or Assistance to Residents in County Homes (ARCH) programs. This policy limitation hinders consumer choice and independence and deprives consumers of some additional housing options that may better meet their needs and better serve the State's interests. Additionally, since ARCH is a government-funded program, ARCH recipients are not allowed to be enrolled in Medicaid, so the State picks up 100% of all healthcare costs.

Action: Indiana's Residential Care Assistance Program policy should be modified to allow consumers to choose how their funding is used; i.e., to either live in a room and board assistance setting, or to use up to the same amount for temporary tenant-based rental assistance. If the consumer could choose to use these state funds as temporary tenant-based rental assistance until affordable housing such as a Section 8 Housing Certificate is applied for and obtained, the opportunities to live and perhaps work in the community are enhanced. Funding should follow the client regardless of living environment.

Target Population. Persons who would be affected by this change are low-income elderly and disabled adults who qualify for assistance under the State RCAP program.

Policy Outcomes. Implementation of this Action will introduce a much-needed flexibility to the RCAP program. If RCAP funds could be used to obtain temporary tenant-based rental assistance until a consumer can qualify for affordable housing options such as Section 8 Housing, then (s) he would move off the RCAP program, opening a new slot to assist another person. Not only could more individuals be served by the RCAP program, but also more could enjoy a more independent living situation within the community. Additional benefits may include increased consumer independence, community tax benefits if the consumer obtains employment, decreased risk of institutionalization, improvement in quality of life, and improved management and possible savings of state healthcare costs. Moreover, implementation of this Action may mitigate the likelihood that litigation related to unlawful segregation of persons with mental illness will by filed against the State.

System Barriers. Successful implementation of this Action will require a rule and/or statutory change, computer system changes, and administrative changes in procedures. Other barriers include: a lack of understanding about the characteristics of RBA clients (i.e., a mistaken belief that all persons receiving RBA need a high level of care); buy-in by state agencies, institutions, and case managers; resistance by RBA providers; lack of educational information for consumers *about* housing opportunities and state program purpose and policies; lack of reliable baseline data; lack of an appropriate system for measuring outcomes; lack of appropriate supports and oversight of consumers who participate in the RCAP/RBA program; and lack of an established partnership with housing providers to assure that consumers who are awaiting Section 8 Housing receive safe and appropriate temporary housing in the interim.

Responsible Agencies and Action Steps. The Division of Disability, Aging and Rehabilitation Services, the Division of Mental Health and Addictions, and the Division of Family Resources within the Indiana Family and Social Services Administration will be responsible for pursuing and implementing this change. Action steps include:

- Completion of a written review and evaluation of the RBA and RCAP programs.
- Promulgation of a rule change and/or pursuit of legislation to modify state statutes.
- Establishment of a collaborative partnership between responsible state agencies and housing providers (both RBA and new providers).
- Development of specific program criteria for RCAP.
- Development/modification of an effective data collection system that enables consumer information and funding to be readily identified and followed
- Development of benchmarks to measure outcomes.
- Modifications to the computer system.

*Fiscal Impact***.** The costs of implementing this action will likely consist of two main elements:

- Monthly savings for the State/Medicaid: If the same number of slots currently available are used as a reference, the State could save money by spending less for tenant-based rental assistance than what is currently being paid for all of the individual's community living needs. Currently, the State pays roughly $1,200 per person per month in the RBA program less the individual's contribution of SSI monies. In addition, the State pays $660 per person per month in the ARCH program. The State also pays full medical and healthcare expenses for individuals in the ARCH program. If ARCH individuals went to tenant-based rental assistance, the individual could enroll in Medicaid, and the State share would only be 38%, compared to 100%. An individual on either program would pay approximately $300 per month for rent with tenant-based rental assistance, and would save the State either $300 for ARCH or $800 per month for RBA. This could be used in the short-term to pay for the expenses of changing the system.

- Impact on Tenant Based Rental Slots: As individuals become eligible for affordable housing such as Section 8 Housing subsidy or Mainstream vouchers for persons with disabilities, the individual would no longer need/receive tenant-based rental assistance, thus opening up TBRA slots for others. The funds could then be used to support new persons coming into the system.

Targeted Completion Date. This Action should be implemented by July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons served by the RCAP program
- Decrease in the average length of time per consumer RCAP program services are provided
- Increase in the utilization of temporary tenant-based rental assistance

Problem: The U.S. Surgeon General has estimated that 20% of the American population has some mental disorder in a given year, and about 5% of the population is considered to have a serious mental illness (SMI). Based on these figures, an estimated 305,000 people in Indiana are expected to experience some form of mental illness each year, 68,000 of which are likely to qualify for publicly-funded services.[19] Currently, the Indiana Division of Mental Health and Addiction serves 41,000 persons in state hospitals and in the community mental health system.[20]

Mental health services provided in a community setting have proven to represent a much more cost-effective, desirable, and successful alternative to care provided too many persons in traditional institutional settings. Nevertheless, Indiana has never had available the funds necessary to develop a sufficient number of community service alternatives to meet the needs of its low-income, mentally ill and dually diagnosed (mentally ill/developmentally disabled) populations. Moreover, although some persons with mental illness have a serious disability that renders them eligible for Medicaid and nursing home care, many do not. As a result, they are not eligible for services funded by a Medicaid home and community-based services waiver. Although Indiana funds many services through the community mental health system and Medicaid (through the Medicaid Rehabilitation Option), there continue to be a number of persons who are served in state hospitals who could successfully and cost-effectively be served in an alternative community setting if one were available (it is, however, also important to note that there are some persons for whom an institutional setting is the service of choice and/or where an individual's needs can best be met).

Action: Implement a Medicaid Home and Community-Based Services Waiver for persons with mental illness that includes people who are dually diagnosed (developmental disability and mental illness and/or mental illness and substance abuse) and support a number of complementary initiatives that are currently underway to further expand the community service alternatives for persons with mental illness.

Target Population. Those who would be affected by this change are certain low-income persons with mental illness and dual diagnosis (developmental disability and mental illness and/or mental illness and substance abuse) and who meet institutional eligibility criteria (i.e., state operated facilities, nursing homes, or intermediate care facilities for the mentally retarded).

Policy Outcomes. The development and implementation of a new Medicaid Home and Community-Based Services Waiver for Persons with Mental Illness will bolster the community-based service options already provided in Indiana and will help to prevent unnecessary institutionalization. More persons with mental illness can be served through the Medicaid Waiver and at less cost than in the equivalent institutional setting. Successful and consistent community treatment outcomes will positively influence overall healthcare costs, and the consumer's health, level of independence, employment retention, and quality of life. Institutional resident census may be decreased, and overall state institutional costs may be reduced.

System Barriers. The system barriers include: lack of information about how to access programs and funds among providers, consumers, and families; lack of affordable and accessible housing; lack of funding for supported employment and supportive housing; lack of available jobs and transportation; and lack of adequate personal care services provided in the individual's or family's home. Other barriers include: resistance from state staff to develop, implement and monitor the new waiver program; computer system changes that may be complex, costly and time-consuming; and lack of funding. Without additional resources, the Indiana Family and Social Services Administration may not have the staffing or expertise in development and oversight of an additional Medicaid Waiver Program, which by definition, carries with it separate administrative and Federal reporting responsibilities.

There are also a number of barriers related to Medicaid coverage of persons with mental illness. Federal regulations specify that Federal financial participation is only available in institutions for mental diseases (defined as institutions with more than 16 beds[21]) for individuals less than 21 years and 65 years or older. This creates a gap in funding for adults between the ages of 22 years and 65 years (See 42 CFR 441.11). Since, Medicaid home and community-based services waivers are specifically defined as a service option to be used in lieu of institutional care, Medicaid funding that is not available for certain populations (like persons with mental illness) in an institution can not be made available through a Medicaid waiver. Furthermore, in applying for a Medicaid waiver, the State needs to demonstrate cost-effectiveness by comparing costs for the population to be covered in the waiver to the costs of their care in an institution. Therefore, if Medicaid does not cover the costs of institutionalization, there is no cost comparison for the provision of services in the community.

It is also important to consider Medicaid eligibility in general. Individuals covered through the Medicaid program are (in broad categories), low-income families receiving cash assistance (TANF), pregnant women, children, and Aged, Blind and Disabled populations. Therefore, persons with mental illness who do not meet any of the Medicaid categorical eligibility criteria, would not be Medicaid-eligible, and would then also not be eligible for a Medicaid waiver program.

Responsible Agency(ies) and Action Steps. The Indiana Division of Mental Health and Addictions, the Division of Disability, Aging and Rehabilitative Services, and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for developing and implementing the new Medicaid Waiver for Persons with Mental Illness. The action steps include:

- Evaluation of what services can be made available to address the needs of persons with mental illness and then determine what funding options can be available.
- Evaluation of Medicaid home and community-based services waivers and other Medicaid waivers for persons with mental illness already implemented in other states to determine the best model for Indiana to pursue. Currently, such waivers exist in the states of Colorado, Washington, California, Michigan, Utah, Texas, and Florida. Some of these waivers are 1915 (traditional model) and others are 1115 (demonstration). Each of these has demonstrated a cost savings.[22]
- Completion of a comprehensive fiscal impact analysis by population targeted and the model to be implemented based on research of the above action step. (This waiver will have very different costs depending on the needs of the population; i.e., whether they are dually diagnosed with mental illness/developmental disabilities or mental illness/substance abuse). Particular attention should be spent on the cost savings documented by other state waiver programs (i.e., Colorado).

- Completion of a fully-developed implementation plan, including development of appropriate Memoranda of Understanding between responsible state agencies for the new Medicaid Waiver, if appropriate.
- Depending upon the research performed above, the Medicaid Waiver should include services such as adult day care, alternative care facilities, electronic monitoring, home modifications, non-medical transportation, respite care, personal care, hearing-impaired services, and homemaker services.
- Submit the Medicaid Waiver application to the Centers for Medicare and Medicaid Services for review and approval.
- Determine whether rules will need to be promulgated.
- Promulgate rules as applicable.
- Ensure adequate quality assurance by investigating independent case management services for persons with serious mental illness.
- Secure State Medicaid Match required to support a waiver initiative for both waiver costs and medical (non-waiver) costs.
- Establish and monitor outcome measurements to quantify cost savings, as completed in other states with waivers for persons with mental illness.

Complementary initiatives that should be pursued are as follows:

1. The Division of Mental Health and Addiction should be encouraged to continue its development of a Medicaid Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance, which will target 50 – 200 youth in the community who are or would otherwise be served in a state mental hospital.
2. The Indiana Medicaid Rehabilitation Option should be modified to include supported employment as a covered service. This policy change will assist in ensuring that people with serious mental illness are better supported in retaining community employment.
3. Vocational Rehabilitation Services should work in providing better information about supported employment, which are funded with non- Medicaid dollars and are currently underutilized.
4. The Indiana Family and Social Services Administration should research the educational benefits of the Texas Medication Algorithm, which provides an option to generic drug substitution, as well as, evidence-based practices for adults and children with mental illness and dual diagnosis. Information should be disseminated statewide.

Fiscal Impact. Since this is a new Medicaid Waiver Program, new funding will be needed for the initial implementation. The fiscal impact will be based on service utilization, and the design, development, administration, and oversight of the program. The cost could be considerably mitigated if state funds that are currently supporting other, related services, such as institutional care, were shifted to this program.

In the longer term, as the waiver program grows, there can be expected a cost savings that results from a significantly-decreased rate of institutionalization for these populations, as well as a decreased length of stay.

Targeted Completion Date. The Indiana Family and Social Services Administration should develop a comprehensive fiscal impact analysis that consists of the following:

- The number of consumers to be served by the program, for each of the first two years;
- Detailed administrative costs related to program design and development (i.e., computer system; staffing; other);

- Expected service costs (both waiver and medical services costs), including estimated provider rates, specialized case management, and direct state staff involvement; and
- Detailed administrative costs related to quality oversight and monitoring, including at minimum: state and/or contract staff; case management; long-term care ombudsman; program auditors; and adult protective services.
- The long-term effects of the shift from institutional care to community-based services; i.e., the estimated decrease in, and timing of, state hospital expenditures; when and by how much overall cost savings will occur.

Researching the desired model to be implemented in Indiana should be completed by September 1, 2003. The associated fiscal impact analysis should be completed by no later than November 1, 2003 and be presented at the final Commission meeting in December 2003. It should be accompanied by a comprehensive implementation plan, also due on November 1, 2003.

Finally, a new Medicaid Waiver for Persons with Mental Illness should be implemented *as soon as possible but only after all funding has been identified and all action steps have been completed*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the institutionalization rates of persons with mental illness
- Increase in the number of persons with mental illness served in the community
- Decrease in the state hospital and acute care hospital readmission rates for persons with mental illness
- Reduction in total state hospital expenditures; increase in per person state hospital expenditures

Problem: Medicare and Medicaid beneficiaries have difficulty in obtaining approval for medically-necessary wheelchair and other durable medical equipment, assistive technology, and timely repair of existing equipment. There is generally no consideration for preventive care in the evaluation of medical necessity, which often leads to costly and painful health outcomes as well as potential limitations or loss of functional independence for the consumer. Written wheelchair and equipment policy generally appears to meet the needs of consumers but may not be implemented correctly or consistently by contracted, regional Medicare fiscal intermediaries or Indiana Medicaid's Fiscal Agent Contractor. Moreover, the consumer's needs are not well-evaluated and coordinated, which sometimes results in the purchase of expensive equipment that can not be used, returned, or replaced. Vendors are sometimes not monitored, and second opinions are not sought, both of which are especially critical since program policy imposes strict limits (time and quantity) on the acquisition of equipment for consumers. Because of these apparently process-related problems, consumers who are dependent upon wheelchair and other equipment and technology often suffer deteriorating health status, loss of employment and/or wages, and displacement from the community.

Action: Medicare and Medicaid wheelchair and equipment coverage policy must be made more flexible to allow for a better evaluation of the consumers needs, consideration of preventive care, and better coordination of vendors.

Target Population. Those who would be affected by this change are Medicare and Medicaid-eligible adults who are frail and elderly and/or have physical or developmental disabilities and/or have mental illness.

Policy Outcomes. Implementation of this Action will significantly increase the consumer's productivity, morale, and quality of life. Since mobility is a basic activity of daily living, consumers who are dependent upon wheelchairs must have safe, reliable, and comfortable wheelchair equipment to allow them to function in the most independent manner possible. Reductions in approval time and processing requirements for wheelchair repair and replacement will positively impact the consumer's general health status, ability to secure and retain outside employment, and overall ability to function. Additionally, better coordination and evaluation of the consumer's needs will reduce and/or eliminate unnecessary expense that occurs when inappropriate equipment is purchased or when policy does not permit a less expensive, more appropriate option.

System Barriers. Since Medicare is a Federal program that is operated by contracted, regional fiscal intermediaries, policies are not always consistently interpreted and applied. Similarly, the Indiana Medicaid Program relies upon a fiscal agent contractor to evaluate and authorize wheelchair and other equipment purchases. As a result, policy concerns expressed by consumers and government officials are not always properly routed and/or responded to, so policy change is very difficult to implement. In addition, consumer outreach is generally poor.

Responsible Agency(ies) and Action Steps. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for implementing this policy change and/or reissuing wheelchair coverage policies to its Medicare fiscal intermediaries and consumers. The Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration is responsible for implementing this policy change within the Indiana Medicaid Program.

Action steps include:

- Review and evaluation of wheelchair coverage policies and processes administered by all Medicare fiscal intermediaries and the Indiana Medicaid Program.
- Determination of non-compliant Medicare fiscal intermediaries and policy/process problems within the Indiana Medicaid prior authorization process.
- Evaluation of wheelchair policy modifications necessary to provide preventive care and improve consumer service and health outcomes
- Determination of whether modification of regulations is necessary; drafting and promulgation of proposed regulatory changes
- Implementation of revised regulations, if necessary
- Implementation of policy and/or process changes
- Development of a consumer education protocol that will assist consumers in understanding coverage policies and changes as they occur

Fiscal Impact. The cost of implementing this Action is expected to be minimal, since it appears that Medicare and Medicaid wheelchair coverage policy already appears to meet the needs of consumers but is not being applied properly by the fiscal intermediaries or the Indiana Medicaid Program's fiscal agent contractor. There may, however, be some increase in administrative costs as consumer needs are more frequently evaluated.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than July 1, 2004. If a change in regulation is required, than the proposed regulation should be published in the Federal Register by no later than December 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the waiting time for wheelchair and other equipment approvals
- Reduction in processing requirements for equipment and equipment repair requests
- Decrease in total per person equipment expense over a period of time

3.2.2 The following action falls under the responsibility of the Indiana Department of Workforce Development

Problem: There are not enough individuals available who desire and are able to provide personal care attendant services and supports to consumers with disabilities who choose to direct their own care. This need for individuals is especially acute in rural areas. Once personal care attendants are trained and experienced, it is even more difficult to retain their employment. This acute need is expected to increase in the near future.

Action: The Indiana Department of Workforce Development should explore the option to provide benefits to increase the number of and retention of personal care workers. This evaluation should be based on the best practices of other states as well as the recommendations that were made in the 2002 Caregiver Commission Report.

Target Population. Consumers who are affected by this change include persons who are frail elderly and/or disabled. Potential caregivers who are affected by this change include individuals who live in the neighborhoods and communities of the persons needing these services; young adults in high schools and technical schools; and persons employed in low wage jobs without health insurance or other benefits.

Policy Outcomes. Implementation of this Action can be expected to grow, possibly significantly, the number of persons willing to become personal care attendants as well as improve the employment retention rates for persons who already serve as personal care attendants. This increase in provider capacity will directly and positively impact consumers by introducing and/or extending the opportunity to remain in the community, decreasing unwanted institutionalizations (thereby further diminishing the longstanding institutional program and fiscal biases), increasing choice among available providers, and enhancing quality of life. In contrast, this change will likely adversely impact the employment and retention pool of lower-wage workers that are currently employed by home health agencies, nursing homes, and hospitals.

System Barriers. Since the State does not typically include benefits in the reimbursement mechanism for services, the implications of this change on other state programs are currently unknown. The fiscal impact may be significant. Benefits will need to be administered, and there may be no state mechanism currently in place to do so. Computer system modifications may be required. Legislation and/or rule promulgation will need to be drafted and pursued.

Responsible Agency(ies) and Action Steps. The Indiana Department of Workforce Development is responsible for implementing this Action.

Action steps include:

- Identification of any personal care attendant benefits programs developed and implemented in other states.
- Evaluation of the administrative, policy and fiscal implications for Indiana.
- Identification of a benefits administrator and program oversight.
- Development of a benefit package.
- Consumer and provider marketing and outreach.

Fiscal Impact. The fiscal impact is unknown until many of the action steps are completed. It is, however, important to determine both the short-term costs and the long-term costs and implications, since enhancement of the personal care provider pool can be reasonably expected decrease institutional (both acute care hospital and nursing home) costs, thereby generating possibly significant savings over time.

Targeted Completion Date. January 2005.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of personal care attendants
- Increase in the employment retention rates for personal care attendants
- Increase in the number of persons receiving community-based services
- Decrease in the number of persons served in institutional settings
- Decrease in the institutional resident census

3.3 Category: Community Capacity

The following eight (8) actions represent initiatives that specifically focus on opportunities to build upon or improve the services and supports that must be in place for consumers to live safely and successfully in a community-based setting. Those agencies or offices identified as responsible for taking the lead include: the Office of the Governor; the Indiana Family and Social Services Administration; the Indiana Department of Workforce Development; and the Indiana Department of Transportation.

3.3.1 The following two (2) actions fall under the responsibility of the Office of the Governor

Problem: Housing issues for individuals who are elderly or who have disabilities, including mental illness, have not been sufficiently addressed, resulting in limited appropriate, affordable, and accessible housing stock for these populations.

Action: The Governor should appoint a Housing Task Force to focus on the housing issues of the elderly, disabled, and mentally ill populations. Membership should include: representatives of the housing industry, especially builders and contractors who have expertise and experience in new construction; consumers; advocacy groups; legislators; representatives of public/private funding sources; and service providers.

Target Population. Those who would be affected by this change are all low-income persons and families who are at risk, including the frail elderly, persons who are physically and/or developmentally disabled, and persons with mental illness.

Policy Outcomes. Establishment of a Housing Task Force will facilitate a much-needed collaboration among housing and community program and services administrators, providers, and consumers to explore public-private partnerships needed to develop more housing options for the elderly, disabled, and mentally ill populations. The Task Force will further assist the State in formalizing the critical link between availability of safe, affordable, and accessible housing with the community services needed to promote consumer choice and quality of life.

It is important to note that this proposed Housing Task Force differs from the Low Income Housing Trust Fund Advisory Committee (previously recommended to be re-appointed) in that the Committee's primary purpose is to make recommendations to the Housing Finance Authority regarding the identification of long-term sources to capitalize the housing trust fund, including: revenue from development ordinances, fees, or taxes; market-based or private revenue; and revenue generated from government programs, foundations, private individuals, or corporations.

In contrast, the purpose of this Housing Task Force would be as follows:

- To facilitate development of innovative housing options for the elderly, disabled, and mentally ill populations.
- To develop and define specific plan/expected outcomes for housing for these populations.
- To review all state housing plans/programs for duplication of efforts, fairness, and consistency in implementation.

- To serve as a policy and planning advisory group to the Governor on housing issues for these populations.
- To review and provide input into Indiana's State Consolidated Plan (SCP). Beginning in Fiscal Year 1995, the U.S. Department of Housing and Urban Development (HUD) required states and local communities to prepare a Consolidated Plan in order to receive Federal housing and community development funding. The Plan consolidates into a single document the previously separate planning and application requirements for Community Development Block Grants (CDBG), Emergency Shelter Grants (ESG), the HOME Investment Partnership Program and Housing Opportunities for People with AIDS (HOPWA) funding, and the Comprehensive Housing and Affordability Strategy (CHAS). Consolidated Plans must be prepared every five years; updates to the five-year Plan are required annually. The purpose of the Consolidated Plan is:

  1. To identify a state's housing and community development needs, priorities, goals, and strategies; and
  2. To stipulate how funds will be allocated to state housing and community development nonprofit organizations and local governments.

- To review allocation of Community Development Block Grant funds (In 2003, $5 million of $36 million went to housing).
- To develop guiding principles for the funding and operations of all publicly funded housing programs. Building on the framework already established by the Governor's Commission on Home and Community-Based Services Housing Task Force, the following principles should be considered:
  - Consumers should be encouraged and provided the option to own property or have leases in their own name.
  - Support services should be available and with the consumer's choice be coordinated between housing and service providers to assist individuals to remain in their own home.
  - To the extent possible, agencies providing housing shall make every effort to promote consumer choice in the provision of support services.
  - Sponsors are required to ensure that residents have access to any necessary supportive services but cannot require the acceptance of such as a condition of occupancy.
  - Housing should be integrated into the community.
  - Safe, clean, and affordable housing should be available and targeted to individuals with the lowest incomes.
  - Voluntary, 24 hours a day/7 days a week community-based support services should be available.
  - Consumers must be given real choice in the full range of housing options that are also available to individuals without disabilities.

System Barriers. Resistance from interested parties to forming "another" advisory group is likely. It should be noted that no current Governor-appointed advisory group for housing for these low-income, at risk populations is currently in place. The housing needs for these populations are often relegated to "add-on" task forces for other efforts.

Responsible Agency(ies) and Action Steps. The Office of the Governor is responsible for appointing the Task Force. Action steps include: appointing the Task force members; assigning priority to its function; issuing a written list of directive(s) for the Task force members, including expected outcomes with time-lines; developing a progress report expectation; and issuing one or more press releases.

Fiscal Impact. Dedicated funds will be required to staff and administratively support the Housing Task Force. The costs should be comparable to funds dedicated to support other Boards and similar bodies.

Targeted Completion Date. The Task Force should be appointed by no later than September 30, 2003. The first meeting should occur no later than November 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Selection of dedicated, active Task Force members
- The convening of regular and frequent meetings
- Development of a full and meaningful agenda for those meetings
- Development of a tangible and comprehensive housing plan for the State
- Increase in the number of new and expanded housing options for persons with low-income

Problem: Indiana does not have a dedicated state funding source to develop and support safe, affordable, and accessible housing for at risk families and persons who are low-income, elderly, disabled, and/or mentally ill. As a result, housing options are scarce. Of the few community services that are available, many are not geographically, physically, or financially accessible, so persons may be transient and reside in homeless shelters and go without care, or be unnecessarily institutionalized.

Action: The Governor should work with the Indiana General Assembly to establish a real estate transaction fee to be assessed in the transfer of all commercial, farm, and residential real estate. The proposed fee per transaction would be dedicated to the Indiana Low Income Housing Trust Fund. If a local, low-income housing trust fund already exists within a community, one-half of the funds collection from the fee would be transferred to the local fund and one-half would go to the Indiana Low Income Housing Trust Fund for statewide application.

*Target Populations***.** Those who would be affected by this change are all persons and families who are low income ($\leq$ 80 % Area Median Income), including those who are at risk, the frail elderly, persons with physical and/or developmental disabilities, and persons with mental illness.

Policy Outcomes. Implementation of this Action will create dedicated and expanded funding for low-income housing for persons and families who are at risk and persons of low income and who are elderly, disabled, and/or mentally ill. If directed and used properly, additional housing assistance will:

- Facilitate greater independence among consumers;
- Stimulate the housing market;
- Reduce family separation and disintegration;
- Reduce domestic violence/child abuse;
- Decrease dependence and utilization of institutional services;
- Decrease utilization of homeless shelters;
- Reduce incarceration of consumers;
- Increase employment;
- Improve health outcomes;

- Improve quality of life; and
- Assist in fulfilling the charge of the Low Income Housing Trust Fund Advisory Committee.
- Positive impact on property tax revenues

System Barriers. Given the current economic climate and the severe budget constraints that Indiana is experiencing, it will be difficult for legislators to realize the value and importance of imposing a fee and developing a new housing assistance program dedicated to persons with low-income. Success will require the thoughtful compilation of a great deal of information, including relevant data and statistics that profile the needs of the at risk populations, current service utilization and cost data, and that fully evaluates the short- and long-term implications of retaining the status quo and imposing a new fee. A new funding and accounting structure will need to be developed and administered. Management and oversight of the Indiana Low-Income Housing Trust Fund may need to be expanded and/or modified in some way. Potential opposition from certain interest groups is anticipated.

Responsible Agency(ies) and Action Steps. The Office of the Governor will need to take the lead (or assign it as appropriate) to develop and garner support for the imposition of this new transaction fee. Other action steps include, but are not limited to:

- Completion of a comprehensive written analysis (as described in Systems Barriers above) that fully profiles the needs of the at risk populations, the implications of imposing the tax, anticipated outcomes, and cost/fiscal effects to the State in both the short- and long-term.
- Evaluation of the Low-Income Housing Trust Fund composition, structure, management, oversight, and accountability.
- Development of an accounting process to collect the fee and distribute funds.
- Development of a protocol for how the funds will be distributed and used.

Fiscal Impact. The fiscal impact of implementation of a real estate transaction fee has not been fully determined. If, for example the fee were $25 per transaction, based on a previous estimate of 200,000 real estate transactions per year, the fee could generate approximately $5,000,000 annually. Administrative costs would include costs associated with implementing and managing the funds created by this fee. The written analysis described in the Action Steps should include a complete evaluation of the short- and long-term costs and/or savings to the State.

Targeted Completion Date. The comprehensive written analysis of this new fee initiative should be completed by no later than January 1, 2004. Legislation should be pursued during the 2004 Legislative Session, and should become effective on July 1, 2004. The new fee should begin being assessed and collected by no later than September 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Successful legislation that imposes a real estate transaction fee
- Establishment of a collection and reporting mechanism for the fee
- Dedication of the fee to low-income housing
- Increase in the number of new housing initiatives
- Expansion in the number of existing housing programs/initiatives
- Increase in the number of low-income persons who receive housing assistance

3.3.2 The following two (2) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: Statewide hourly rates for employment services provided through Indiana's Vocational Rehabilitation Program were established over ten years ago at $36.96 per hour. Since that time, only one rate adjustment has occurred, *and* vendors have had to absorb higher cost to retain and recruit qualified staff. Some agencies have stopped providing employment services due to increased cost and loss of large amounts of revenue-thus resulting in limited availability of timely employment services for those consumers in need.

Action: The current Vocational Rehabilitation Services rate (for supported employment and hourly-based placement) should be adjusted by utilizing a standard rate-setting methodology that includes an annual formula for inflationary increases. This methodology could include an hourly or results-based formula.[*]

Target Population. Those who would be affected by this change are providers/vendors of supported employment and placement services and consumers seeking employment. The eligibility criteria for vocational rehabilitation services are:

1. The applicant must have a physical or mental impairment;
2. The physical or mental impairment constitutes or results in a substantial impediment to employment;
3. The applicant requires vocational rehabilitation services to prepare for, secure, retain, or regain an employment outcome consistent with strengths, resources, priorities, concerns, abilities, capabilities, and career interests of the individual;
4. The applicant can benefit in terms of an employment outcome from vocational rehabilitation services.

Eligibility criteria for supported employment services are:

1. The applicant must meet three or more functional capacity areas and requires multiple vocational rehabilitation services over an extended period of time;
2. Competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent;
3. The applicant will require intensive supported employment services from Vocational Rehabilitation Services with follow along services from the provider.

Policy Outcomes. By increasing the rate paid to providers/vendors to a competitive level, providers would be better able to attract skilled professionals that offer specialized employment services to individuals who have the most significant disabilities. Consumers would be better trained to secure and maintain employment in the community in integrated settings, would achieve greater independence, and would contribute to the common good of the community. Consumer reliance on public assistance may be reduced, health outcomes and quality of life will improve, and unnecessary institutionalization will be minimized or avoided altogether.

[*] Note: The Results-Based Funding work group recommendations to move toward results-based funding may be implemented and would supercede this recommendation.

System Barriers. Depending on the amount of additional funds needed to support this rate increase, the Indiana Family and Social Services Administration may attempt to fund this rate increase in an undesirable way by reducing the number of persons served, rather than by seeking additional funds. Computer ***s***ystems will need to be modified to accommodate the new rates. Providers and consumers will need to be notified of the rate changes.

Responsible Agency(ies) and Action Steps. Vocational Rehabilitation Services, the Division of Disability Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing these changes.

Other action steps include the following:

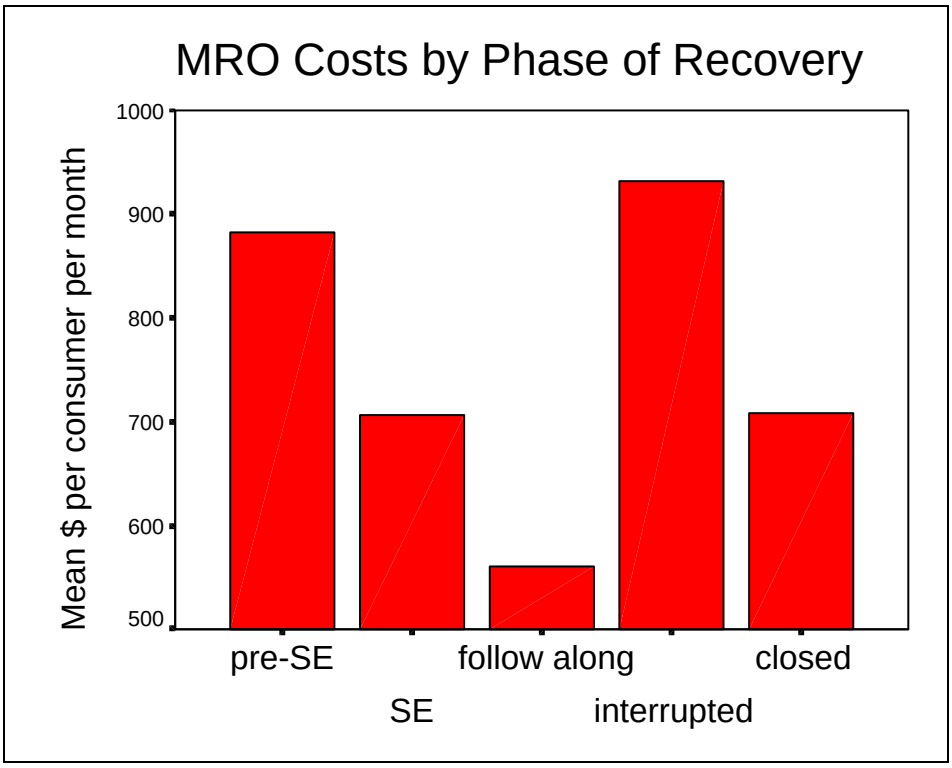
- The existing Results-Based Funding work group should complete work and make recommendations.
- Division of Disability Aging and Rehabilitation Services must complete a review and comparison of the current vocational rehabilitation rates to similar rates in other Indiana programs and/or to similar rates to programs in other states.
- Division of Disability Aging and Rehabilitation Services must determine further rate changes and implementation processes that are necessary to implement a standardized rate methodology
- Providers and consumers will need to be informed of the rate changes and any applicable changes in the billing process.
- Computer system modifications will need to be designed and implemented.

Fiscal Impact. The cost of implementing this change will depend upon the rate study findings and the impact of a rate change on other programs within Division of Disability Aging and Rehabilitation Services (i.e., BDDS) that purchase similar services and have the same eligibility criteria as vocational rehabilitation services. While initial start-up costs are certain, it is important to note that *for every dollar spent on vocational rehabilitation services, a consumer earns $13.00 in increased taxable earnings. The cost of vocational rehabilitation is paid back in taxes in two to four years.*[23] Increased employment may also have a positive impact on the tax base, Medicaid, residential programs, and the Medicaid Rehabilitation Option (MRO). Please see the graph provided below.[24] Finally, Indiana needs to continue to work with the state legislature to secure all of the available Federal funding for vocational rehabilitation services by providing the necessary state match (21.3%) to secure and draw down Federal funds.

Targeted Completion Date. The rate study should be completed by no later than January 1, 2004. Identification of funds should occur immediately thereafter, with changes in the rate methodology occurring by no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number and type of specialized employment services.
- Increase in the retention rates of employed consumers.
- Increase in the number of consumers employed in integrated employment settings.
- Decrease in institutionalization rates of employed consumers.
- Increase in consumer satisfaction.



The above graph presents the mean dollars per month billed to Medicaid Rehab Option funds for SE consumers at Indiana mental health centers from 1997-2000, as a function of the stage of vocational recovery consumers were in. That is, in the 3 months prior to beginning SE, consumers averaged about $900 per consumer per month billed to MRO. During active SE (job development, initial months of work) consumers averaged about $700 per consumer per month billed to MRO. During follow-along (a stable phase of continued work) the average billed to MRO was about $550 per consumer per month. For those consumers whose vocational recovery was interrupted (due to relapse or other setback), there was an average of about $950 billed to MRO per consumer per month. Finally, consumers closed from all vocational support required about $700 of MRO-supported services per month.

Problem: Indiana uses multiple funding streams, including its CHOICE program, to provide services and supports to older Hoosiers and persons with disabilities who are at risk of losing their independence. Availability and funding for services is often inconsistent across programs even though the services needed are the same. Competition for individuals who provide these services also varies between some rural and urban areas.

Action: The Indiana Family and Social Services Administration should develop a standardized, statewide rate ceiling for similar services provided. This should be established across all programs and be based on (or be responsive to) the actual cost of services being provided.

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled and are at risk of losing their independence or are living in more restrictive settings but are able and willing to live independently.

Policy Outcomes. Implementation of this action will increase the number of providers willing to participate in the Medicaid waiver and other public assistance programs. This increase in the provider base will stimulate consumer choice of providers and should as a result improve service quality.

*System Barriers***.** There may be individual program and funding limitations established by statute and/or rule that make rate standardization with other programs difficult or impossible to implement without formal modification (either by legislation or through the rule promulgation process). Multiple computer systems will need to be modified, which may be complex and/or time-consuming. For community-based providers, there is no established method for collecting historical cost information and calculating payment rates based on cost, thereby a new methodology will need to be developed and implemented. Standardization of payment rates may require some rates to be lowered and some to be raised, especially given the current state budget limitations, which may generate provider objections. Evaluation and comparison of all similar services and corresponding payment rates may be resource-intensive for state staff and thereby generate resistance.

Responsible Agency(ies) and Action Steps. The Division of Disability, Aging and Rehabilitative Services, the Division of Mental Health and Addiction, the Office of Medicaid Policy and Planning, and the Division of Vocational Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing this Action.

Action steps include:

- Identification of all state programs that have similar services.
- Evaluation of the payment rates for each service.
- Evaluation of any program limitations that prescribe payment levels (i.e., mandated in statute and/or rule).
- Development of a cost collection process and a payment methodology that uses provider costs to determine rates.
- If applicable, development of proposed legislation and/or promulgation of a rule change.
- Evaluation and modification of compute system changes.
- Coordination among all state agencies to establish initial standardized rates and to modify rates in all programs simultaneously as future changes occur.

- Educational outreach to providers and consumers.

Fiscal Impact. The administrative costs associated with this change will depend upon the computer system and process changes that are needed, as well as the staff and possibly contract resources that will be devoted to evaluation of multiple program services and payment rates and development and implementation of a cost collection/identification process and rate-setting methodology. Program costs will depend upon the availability of funds. If no new funds are made available, then rate standardization will create an undesired outcome by reducing all rates to that rate that represents the maximum allowed by the program; this will actually produce an undesired cost savings. If no new funds are made available but rules and other statutory limitations are modifications, then standardization could be implemented in a cost neutral way by raising some rates and lowering others.

Targeted Completion Date. January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of participating providers.

3.3.3 The following two (2) actions fall under the responsibility of the Indiana Department of Workforce Development

Problem: Collaboration between employment initiatives and the private sector has been limited in the past. Indiana is lacking sufficient public/private sector partnerships and other collaborative employment initiatives that facilitate employment support for consumers in need of assistance in securing and maintaining gainful employment. As a result, consumers have limited opportunities to successfully work in integrated employment settings within the community.

Action: A Business Leadership Network should be developed in Indiana to establish and further strengthen the link between business and employment at the local and state levels. Business Leadership Networks assist employers by exploring methods to more effectively recruit, market and hire the talents of job applicants with disabilities. Business Leadership Networks have been developed across the country as part of an initiative started by the Office of Disability Employment Policy (ODEP) and supported by the U.S. Chamber of Commerce. Formation of a Business Leadership Network in Indiana will potentially expand employment opportunities for individuals with disabilities and/or mental illness. A similar effort has been successfully replicated in 38 other states.

Target Populations. Those persons affected by this change include individuals with a disability who are seeking employment.

Policy Outcomes. Implementation of this Action will expand awareness of the value of the available labor pool of individuals with a disability and/or mental illness, increase collaboration between providers/vendors and local/state employers, and increase employment outcomes for people with disabilities in unsubsidized employment. In addition, an expanded awareness of consumer needs on behalf of businesses and community employers would be facilitated.

System Barriers. Administrative considerations are the only significant barrier identified. Participation of local chambers of commerce and community business leaders will be required for the success of these networks.

Responsible Agency(ies) and Action Steps. The Indiana Department of Workforce Development, in cooperation with the State Human Resources Investment Council and the Division of Disability, Aging and Rehabilitation Services and the Vocational Rehabilitation Division within the Indiana Family and Social Services Administration are responsible for this Action. The specific action steps are currently dependent on grant funding. The intent of the grant as written is to "tie" funding to participation in the Workforce Investment Boards (WIBs). If grant funding is secured, a community business leader would need to be identified in order to proceed with development of the Business Leadership Network. There are Business Leadership Networks that have been established in Indianapolis and Evansville; both resources should be utilized when developing and implementing others.

Fiscal Impact. The costs associated with this Action are expected to be minimal and related only to administrative changes/activities (facilitation, start-up, etc.). The Indiana Department of Workforce Development is currently pursuing a Federal grant to support development of such a network and will seek alternate funding, possibly through expanded partnering in the business community, if the grant is not awarded.

Targeted Completion Date. This Action should be implemented by no later than January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of participating local chambers of commerce and community business leaders
- Increase in employment and retention rates of persons who are disabled
- Increase in the number and type of employer/provider partnerships

Problem: Indiana has no state-wide employment standards for staff qualifications, outcomes, and provision of services. As a result, employment services for persons with disabilities and/or mental illness are inconsistent, staff training may be insufficient, and consumer outcomes are not always favorable. This lack of standards severely limits the consumer's opportunity to achieve maximum independence and quality of life. Without the necessary supports, successful, integrated employment becomes difficult and/or impossible to achieve. While CARF accreditation is required for all Vocational Rehabilitation Services (VRS) vendors/providers, the standards are not considered stringent enough to achieve the outcome of improved service to the client.

Action: Employment standards for staff qualifications, outcomes, and provision of services should be developed to ensure a level of professionalism in the delivery of employment services to individuals who are disabled and/or mentally ill. VRS should modify and require that all vendor/provider contracts include language that ensures compliance with the standards as they are developed.

Target Population. Those who are affected by this change are individuals who have a physical and/or developmental disability and/or mental illness.

Policy Outcomes. Professional development and standards compliance within all agencies offering employment services would enhance the quality of services delivered. Employment staff who are highly trained in the development and provision of employment services will have the skills necessary to facilitate the development of effective person-centered plans with consumers. The staff will also possess the sophisticated marketing skills and techniques necessary to develop job openings with employers. Working knowledge of the Americans with Disabilities Act, assistive technology, and reasonable accommodations will be enhanced, thus providing additional strategies when working with new employers.

System Barriers. Successful implementation of this recommendation will require identification of the agency responsible for oversight of standard implementation. There may be additional costs imposed upon vendors/providers. In addition, associations/advocacy groups might perceive the development of standards to be an encroachment on current professional educational/licensure requirements.

Responsible Agency(ies) and Action Steps. The Division of Disability, Aging and Rehabilitation Services and Vocational Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing this Action. Action steps include: the development of standards and an implementation process that includes all stakeholders; the promulgation of administrative rules; and collaboration with vendors/providers to provide education outreach and training.

Development of the standards will require a team of interagency partnerships with Vocational Rehabilitation Services, Department of Labor, Indiana Workforce Development, Department of Education, Division of Mental Health and Addictions, as well as other entities that have expertise in the area of employment (such as the Indiana Institute on Disability and Community, the Supported Employment Consultation and Training Center, Indiana Association of Rehabilitation Facilities (INARF), and the Indiana Council of Community Mental Health Centers). Upon completion of the standards, their incorporation into all contractual agreements/Purchase of Service Agreements offered by the State to vendors wishing to provide employment services should be required.

Fiscal Impact. Costs associated with this Action are expected to be primarily administrative in nature, and thereby minimal. A positive impact of this is that with increased skills, employment outcomes would be enhanced through a more effective job training experience. A favorable impact on job retention and employer satisfaction would be expected, thus minimizing the costs associated with retraining due to turnover.

Of note is concern that requiring high skill levels on behalf of vendors/providers may necessitate similar requirements in state agency staff. Consideration should be given to assure equity across state agencies relative to training and experience requirements for given state agency positions. For example, inequity in the Department of Workforce Development and Vocational Rehabilitation Services positions may create negative changes in the work environment at Work One Centers.

Finally, attention should be given to the need to manage costs by assuring that costs to small providers are not so prohibitive that competition is limited, thereby negatively impacting consumer choice.

Targeted Completion Date. Provider standards should be implemented by no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Improvement in the quality of services provided (determined by surveys, etc.)
- Increase in the number and type of job opportunities for persons with disabilities

3.3.4 The following two (2) actions fall under the responsibility of the Indiana Department of Transportation

Problem: There are seven Public Transportation Corporations (PTCs) in Indiana that provide a combination of fixed route and demand-responsive, accessible transportation service to the general public. The seven PTCs are located in Bloomington, Fort Wayne, Gary, Indianapolis, Lafayette/West Lafayette, Muncie, and South Bend/Mishawaka. The PTCs are municipal corporations created by city council ordinances, and are governed by a board of directors appointed by the city councils and mayors of their respective urban areas.

The Office of the Attorney General has strictly interpreted the statute that establishes these entities (I.C. 36-9-4) and has determined that PTCs are not permitted to provide service outside of their taxing districts. Five PTCs have corporate boundaries that extend one mile outside the city limits plus one additional mile for every 50,000 in population, or major fraction thereof, in the municipality (IC 36-9-1-9(b)). The service district of the Indianapolis PTC (IndyGo) extends to the Marion County line. The service district of the Bloomington PTC (Bloomington Transit), and any other PTCs created after 1982, is limited to the city's corporate limits with no fringe. The Indiana Code was amended in 1982 and no PTCs have been created since then. This creates a problem because the PTCs are prohibited from providing consumers with transportation services needed to access medical and social service appointments and shopping centers that have moved out of the urban taxing district. This severely limits access to essential services for at-risk populations.

Action: The statute that currently limits the service area of a Public Transportation Corporation (PTC) to its taxing district should be reviewed by the Indiana Office of the Attorney General, and, if necessary, amended by the Indiana General Assembly to allow for the provision of the most efficient and effective transportation options for all Hoosiers.

Target Population. Those who would be affected by this change are all persons who utilize the services provided by PTCs, especially low-income persons who are elderly and/or have disabilities or mental illness. I.C. 36-9-4-10 specifies that a PTC is created by an ordinance of a municipal legislative body, or a city council. Current law does not allow for the creation of a PTC in a rural area.

Policy Outcomes. Implementation of this Action will allow public transportation providers to provide critical services to expanded areas within urban communities. This will improve access to both essential and non-essential services for all persons who use public transportation, but especially to low-income elderly and persons with disabilities and/or mental illness. Better

access to needed services will likely positively impact health outcomes of at-risk persons, since transportation will no longer be a barrier to receiving necessary healthcare, and it will improve the likelihood that at risk persons will seek and retain employment.

System Barriers. This change may provoke resistance from the private transportation industry and opposition from city businesses and residents against taxing and spending outside of their district. There are many private bus operators who object to any public operator providing service to anyone, anywhere, because they are using equipment that is subsidized with taxpayers' money and/or using tax funds to pay operating assistance. There have been intense discussions, lawsuits, and legal battles for decades over the issue of public operators providing charter service. The private charter operators object on the grounds that it is unfair competition. In some cases, it is legitimate competition, however, in many cases, the trips would never happen if the public operator did not provide the service because the requesting organization cannot afford the higher rates charged by the private operators.

It is possible that the Attorney General will not agree to a complete review of the statute, or that their review will continue to conclude that the service area is limited. If either of these outcomes occurs, then legislation to amend the statute should be drafted and pursued.

Responsible Agency(ies) and Action Steps. The Indiana Office of the Attorney General and the Indiana Department of Transportation (INDOT) share responsibility for implementing this Action . Action steps include:

- Request that the Attorney General review the previously-issued legal opinion regarding service area limits.
- Request that the Attorney General issue an opinion regarding the previous interpretation.
- If the Attorney General issues a revised opinion stating that the Public Transportation Corporations may go outside their taxing districts, then expanded transportation may occur immediately.
- If the Attorney General issues a revised opinion stating that the Public Transportation Corporations may not go outside their taxing districts, then INDOT will need to develop, promote, and pursue a legislative proposal to expand the service areas.
- Educational outreach and training of consumers and providers will be required.
- INDOT should examine the funding formula for rural transit providers to assure that access to public transportation for Hoosiers in rural and suburban areas is not diminished

Fiscal Impact. There is no anticipated fiscal impact associated with this Action . If the Attorney General decides that a PTC can go outside of their taxing district, increased expenses for the urban provider could occur. If there are rural providers close to the PTC, decreased income from fewer trips provided could also occur.

Cities might actually benefit from more service beyond its taxing district because city residents could access employment opportunities beyond their boundaries and then bring their salaries and their ability to pay taxes back into the city.

Targeted Completion Date. Should the Attorney General agree to review the relevant statute, the review should be completed by January 1, 2004. If necessary, legislation that amends the geographic service areas of the PTCs should be introduced during the 2004 legislative session, with an effective date no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons with disabilities who utilize public transportation.
- Decrease in the number/percentage of missed healthcare appointments for persons with disabilities.
- Increase in the employment and employment retention rates of persons with disabilities.

Problem: There is insufficient public mass transit available in Indiana, especially in rural communities. This lack of available transportation services disproportionately impacts the low-income population, particularly persons who are elderly and persons with disabilities and/or mental illness. Transportation is essential for meeting basic healthcare, social, and employment needs. Lack of transportation is another barrier that contributes to institutional bias, since it significantly hinders an at-risk consumer's ability to receive necessary services and supports in the community.

Action: Funding for public mass transit should be increased so that all citizens have access to adequate, affordable, accessible public transportation.

Target Population. Those who would be affected by this change are all persons who utilize the services provided by public mass transit, especially low-income persons who are elderly and/or have disabilities or mental illness.

Policy Outcomes. Implementation of this Action will allow public transportation providers to provide critical services to expanded areas within Indiana. This will improve access to both essential and non-essential services for all persons who use public transportation, but especially to low-income elderly and persons with disabilities and/or mental illness. Better access to needed services will positively impact health outcomes of at risk persons, since transportation will no longer be a barrier to receiving necessary healthcare, and it will improve the likelihood that at risk persons will seek and retain employment.

System Barriers. Since Indiana has many rural communities, public mass transportation is not able to operate cost-effectively and efficiently. Therefore, innovative approaches to providing public transportation in these areas are essential. Public transportation in urban centers within the State need to be designed (or re-designed), implemented and monitored to assure adequate access to and safety of persons who are elderly and who have disabilities and/or mental illness. There is currently in place a moratorium for the funding of feasibility studies and operating assistance for new systems, therefore little evaluation of transportation systems has occurred. Nevertheless, the demand for service in areas without transit service and the demands to increase service in areas with limited transit service far exceed the limited growth of Federal funding and the stagnation of any growth in state funding over the last few years. The combination of inflation, no growth in funding, and the addition of 17 new systems over the last few years has had a negative impact on existing systems.

The Indiana Department of Transportation (INDOT) has traditionally been devoted to highway construction, and while it has greatly increased its interest and role in public transit, rail, and aviation, it is still dominated by highway interests. As a result, it is not likely that INDOT would take the lead in using any new gas tax revenues for public transportation.

Responsible Agency(ies) and Action Steps. The Indiana Department of Transportation is responsible for implementing this Action. Action steps will include:

- Completion of a study of the use of Surface Transportation Project (STP) funds, Congestion Mitigation & Air Quality (CMAQ), and other funds to determine how those funds can enhance public transportation. The study should include a comparison of Indiana to other states.
- As the gas and/or sales tax increases, INDOT should develop draft legislation that will increase the Public Mass Transportation Fund (PMTF) share.
- Communities with approved public transportation feasibility studies should receive start-up and operating assistance.
- Willing/interested communities without feasibility studies should be provided assistance by INDOT to complete feasibility studies.
- Regarding funding opportunities, increasing existing sources appears to be the most effective method in which to gain monies. At the state level, this could be achieved by either increasing the PMTF share of sales tax revenue, or by using part of gas tax increases to enhance the PMTF. A legislative proposal at the Federal level, known as the Transit Needs Adjustment Initiative, is underway that INDOT reportedly supports. It addresses equity in distribution of the share of Federal gas tax that goes to public transportation. It would guarantee a return of 95% and if passed, would mean an increase for Indiana. If it had been in effect in 2002, Indiana would have had a 68% increase in Federal funding for public transportation.

*Targeted Completion Date***.** INDOT should complete the study of possible funding sources by no later than January 1, 2004. If necessary, a legislative proposal should be drafted and pursued during the 2004 Legislative Session that will expand funding for public mass transit, with an effective date of no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons with disabilities who utilize public transportation.
- Decrease in the number/percentage of missed healthcare appointments for persons with disabilities.
- Increase in the employment and employment retention rates of persons with disabilities.

3.4 Category: Children at-Risk

The following two (2) actions represent changes that are specifically targeted to improve and/or expand upon the service delivery system for children who are at risk and their families. Those agencies or offices identified as responsible for taking the lead include the Indiana Family and Social Services Administration and the Office of the Governor.

3.4.1 The following action falls under the responsibility of the Indiana Family and Social Services Administration

Problem: Currently, fewer than 20% of Indiana children who are at risk (See attached graphic within this Action) of long-term, out-of-home placement are served by an organized and unified system of care. This creates an inconsistency in how children's needs are addressed by professionals within the various service systems in which children and their families are involved. Often children are involved in two or more of these public service systems, and children and their families experience complex, overlapping and even contradictory "treatment plans" that are physically, mentally and emotionally exhausting. In addition, the services provided to the child and family often do not meet their needs, are unnecessarily costly, and result in less than desirable, long-term outcomes.

Action: The Family and Social Services Administration should assist each Indiana community to implement an integrated and unified system of care that is organized to respond to the needs of children who are at-risk of long-term out of home placement.

A system of care is a "comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families." The infrastructure would be designed in each community, but the core values and principles of a system of care that serve as the foundation of the network and service delivery would be consistent statewide. The system of care should be child and family focused, community-based, and culturally competent. Individualized care that matches the needs of the child and the family with services and supports would be provided in the least restrictive setting through a comprehensive array of services. Integrated across child service systems, services would include case management and care coordination, early identification and timely transitions to eliminate a break in services. Current individual systems of services must be coordinated and organized to promote this system of care concept. Whereas an overall policy direction and the expected outcomes for children and families served by the system of care should be established at the state level, the development and implementation of the system of care must be accomplished by and through the leadership and strengths of each local Indiana community. Services provided within the framework of an organized system of care must be based upon the specific strengths of the family and the child who is at-risk of out-of-home placement.

Target Population: Those who would be affected by this change are children and their families who may be "at-risk", "at imminent risk" or "in risk" status as illustrated in the attached diagram and definition of terms.

Policy Outcomes: A unified system of care is a common-sense approach to children's services that promotes the healthy development of a child's physical, mental, emotional, behavioral, and academic development. It suggests a new way of thinking about services and, when designed properly, consists of a comprehensive array of services that is organized into a coordinated network to meet the needs of children and their families. One of the unique hallmarks of the presence of a system of care is an integrated and single cross-agency service plan for each child and family. It includes a menu of home and community-based services, residential placement, and respite care and involves formal and informal supports and services that are chosen by the family, not simply through input, but by deliberate and informed decision-making. It is an approach that is child-centered, family-focused, community-based, and culturally competent with all services

individualized in the least restrictive environment. A system of care is not a process, a model, or a program. It is a framework that can be used by individual communities based upon that community's special needs, resources, collaborations, and existing service delivery systems to develop a full array of services to meet the needs of children and their families. The replication or transfer of a system of care from one community to another is impractical as a system of care must be developed within a consistent conceptual framework but specifically tailored to the unique qualities and strengths of individual communities. Information and education about the specific meaning of a system of care must be offered by the Family and Social Services Administration in conjunction with other state agency partners, and must precede local implementation

In addition to the outcomes described above, services provided within the scope of a system of care will:

- Decrease the number of costly long-term, out-of-home placements;
- Decrease the length of time a child is in out-of-home placements;
- Allow funds to be used more efficiently; and,
- Re-direct funds more toward prevention and early intervention services without endangering funding for current services and interventions.

System Barriers. Emphasizing the strengths of each Indiana community as well as the various existing service systems and organizing them into a meaningful array of services based upon the principles of a system of care can be the basis for overcoming any impending system barriers. Implementation of this Action will require the establishment of a partnership between the Indiana Family and Social Services Administration and a number of state agencies and entities, community leaders, and children's service providers. Strong leadership and commitment will be required to balance the interests of all parties, design a viable and fully-functional system of care and establish and implement a successful and fully-accountable evidence-based system approach. Changes in computer resources will be necessary, and multiple funding streams will need to be evaluated and carefully selected and utilized to maximize Federal reimbursements. State staff may have difficulty in promoting and accepting change. The affected population will have to be closely monitored to assure that they are not adversely impacted during periods of transition and system change. Educational and training protocols will need to be developed and implemented for all stakeholders.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration will take the lead on this initiative. Other primary stakeholders will include: the Indiana Department of Education; the Indiana Department of Health; the Indiana Judicial Conference; the Indiana Judicial Center; the Indiana Department of Correction; the Criminal Justice Institute; community leaders; and children's service providers. The state partners must model, promote, and enhance the coordinated approach expected of local collaborative efforts in order to meet the outcomes expected for children and families served by a system of care. It is imperative that an organized system of care is understood consistently through a clear communication of statewide policy and uniform training, is developed locally with a common shared vision, and that continuous quality improvement and evaluation is based upon impartial research. Existing appropriations must be fully maintained and the provision of services to "in-risk" and "at imminent risk" children must not be jeopardized, reduced, transferred or re-directed to pay for new systems development for earlier intervention or prevention services.

The policy direction for the development and implementation of an organized system of care must originate as a state priority initiated by the Governor. His vision must be communicated

clearly throughout state government and local communities so that the Governor's policy is consistently understood but implementation of the policy is managed locally within the framework of the policy by local juvenile justice, child development, academic, mental health and child welfare professionals in collaboration with families. The Governor also should establish a committee of appropriate agency heads to implement and be accountable for the system of care concept and to resolve inter-agency policy conflicts that will be identified as the system of care is implemented. The committee of agency heads should be responsible to provide statewide input into national strategies and discussions on systems of care, resolve emerging system development issues, provide promising practice information, offer technical assistance to local communities and provide the forum to determine what components of implementation should be consistent or standardized statewide and which should be left to the discretion of the local community. The inter-agency effort should have dedicated staff support to ensure effective policy analysis, data collection, and processing of policy changes and interpretations.

Other action steps that the Indiana Family and Social Services Administration must pursue are as follows:

- A plan must be developed that identifies time-lines, necessary actions, and responsible agencies for statewide implementation of the system of care concept;
- Memoranda of Agreement must be developed and implemented by state and local agencies that identify specific roles in the development, implementation and management of the system of care;
- Training must be developed that consistently communicates the definition and philosophy for a system of care and the implementation strategy for Indiana's system of care vision, both for families who are involved in public systems and for the workers providing and managing the services in the system. Training must help families understand the system of care concept so they are confident in the understanding of the concept and thereby building trust among the families, the service providers and the agencies involved in the system of care;
- System-of-care training must endorse and promote cross-training among appropriate agencies, including child welfare, juvenile justice, mental health, child development and schools;
- Development of fiscal policy that provides an incentive to courts, probation departments, child protective services, child development providers, educational professionals and service providers to maximize appropriate home-based and community services when appropriate and encourages the advancement of prevention and early intervention services, as well as continuous quality management;
- Development of consistent and coordinated needs and service assessments in the juvenile justice, child protective and educational systems that assess a child's safety, assess how well services are matched with the child's and family's needs that set the framework for a single coordinated plan that reduces the need or likelihood of long-term, out-of-home placement. Assessment practices avoid repeated interviews and surveys that yield limited additional information.
- Application for and full implementation of waivers from the Federal government must be pursued, implemented, and fully utilized, including the waivers for the IV-E program, the home and community-based services waiver and the Medicaid Rehabilitation Option (to eventually include not only partnerships with licensed child placement agencies, but also independent providers);
- Administrative funds and reimbursements through the IV-E program and other Federal programs must be maximized to provide the cash flow needed to bring about these systemic changes without increasing program budgets as current systems of services are developed into an organized and unified system of care;

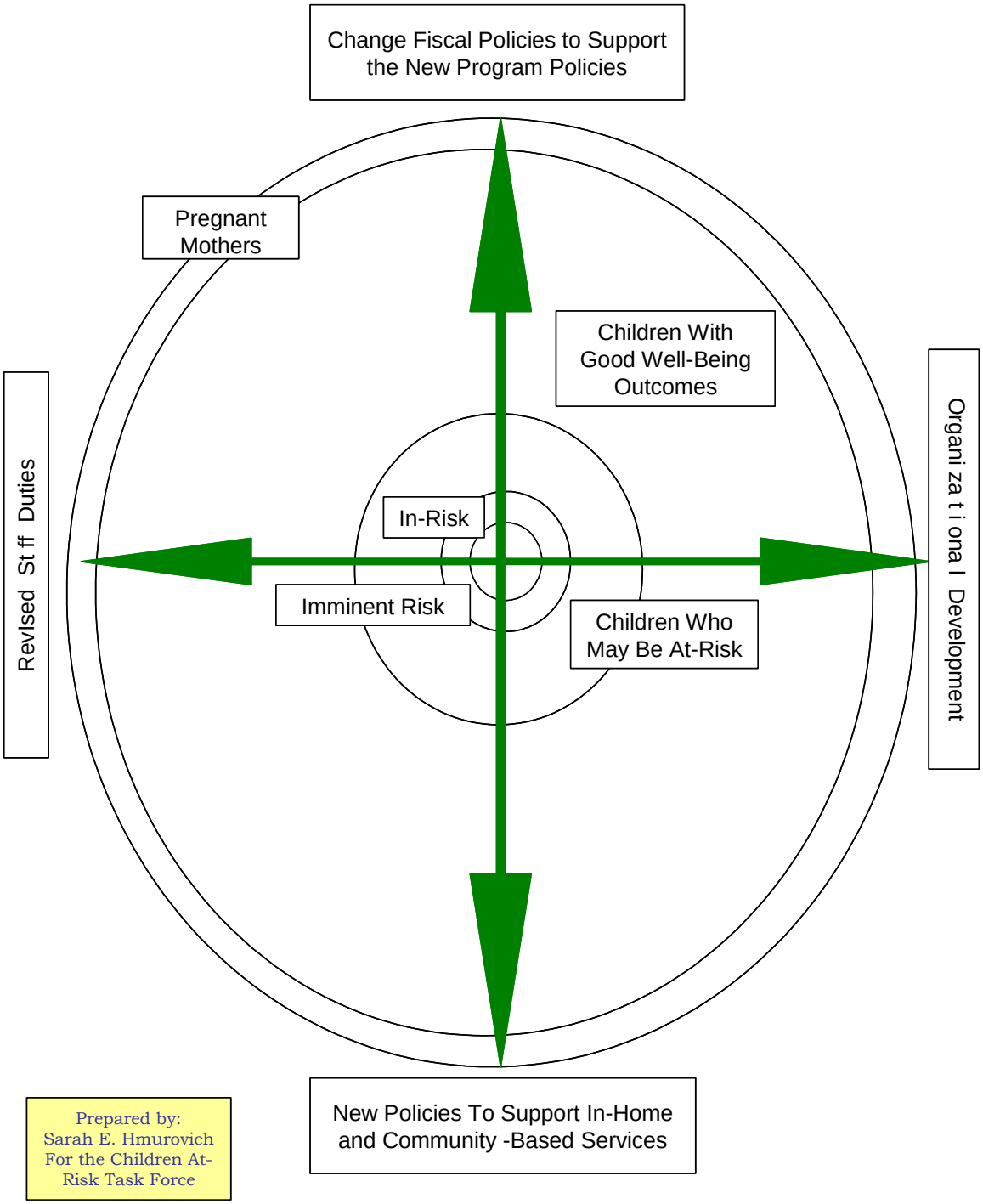
- Enhancement of automated information systems that serve children in the various service systems must be enhanced to provide better coordination of information and more efficient management of services for children in two or more of the systems;
- Consistent implementation of service, case management and eligibility definitions as well as policies concerning the management of information across state and local agencies;
- Collaboration and cooperation among the agency's three service divisions and with other state agencies that provide services to children including quality assurance reviews in the delivery and management of the services based upon recognized performance standards;
- Development and implementation of an automated accounting system that provides the controls and accountability expected by taxpayers for the expenditure of public funds and that provides a platform for state and local agencies to "pool", "braid" or "blend" local, state and Federal dollars, even those not commonly known or used, to maximize cost effectiveness;
- Codification of "best practices" that are available on a website and on-going communication and training processes must be established to provide technical assistance to communities as these organized systems of care are developed;
- Prioritization of evidence-based "best practice" standards so: 1) funds are not removed from other under-funded services; 2) dollars saved through efficiency and better management of services are re-directed to other needed child and family services; and, 3) some administrative savings are realized and used for third party evaluation of the new system to avoid unintended consequences;
- Development of Medicaid funding streams that can enhance appropriate services in schools, local health departments and health facilities;
- Promotion of community capacity in all areas of the state, specifically in the more rural areas that currently may have gaps in the full continuum of children's services.
- Expansion of university and internship programs for psychologists, social workers, educators and other service professionals in conjunction with institutions of higher education and the system of care philosophy should be included in the educational curricula of these professionals;
- Identification of expanded outcomes for the successful implementation of the system of care must be monitored and tracked on an on-going basis in an effort to identify appropriate agency and staff competencies and to serve as the impetus for continuous quality improvement. This will allow Indiana to measure its progress toward a fully integrated system of care;
- Evaluate outcome data against baseline data that is collected for June 30, 2003; and,
- Legislate and implement workload standards that provide adequate time for workers in mental health, child welfare, juvenile justice, schools, and developmental disability areas to work with children and their families.

Fiscal Impact: It is anticipated that the cost of this systems change can be managed within existing state and local budgets, provided: a) Federal program and administrative reimbursements and waiver approvals are maximized, b) thoughtful and deliberate efforts are managed to re-direct appropriate "high cost" out-of-home placements into safe and meaningful community and home based alternatives so as to create necessary cash flow, and c) duplication of efforts in eligibility determination and other administrative inefficiencies are eliminated.

Targeted Completion Date: Every child at-risk of a long-term out-of-home placement will be served by an organized system of care by June 30, 2007.

Benchmarks for Measuring Success. Please refer to the Benchmarks established for the Action listed in Section 3.4.2.

Defining the At-Risk Child



Prepared by:
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For the Children At-Risk Task Force

DEFINING THE AT-RISK CHILD

I. Pregnant Mothers (Prenatal) At-Risk Indicators
1) Tobacco use
2) Alcohol and drug use
3) Lack of healthcare visits in the first trimester
4) Nutrition/diet quality/food insecurity
5) Pregnancies too close together
6) Un-married teen pregnancy
7) Low Birth Weight
8) Housing stability
9) Employment stability

II. Child Well Being Outcomes
1) Living in financial security
2) Housing stability and security
3) Continuous healthcare
4) Nutrition quality/food security
5) Current immunizations
6) Regular well baby visits
7) A family which reads to the child
8) Affordable and quality childcare
9) Support from extended family or friends

III. Children Who May Be At-Risk:
1) TANF recipients
2) Food stamp recipients
3) Free and reduced school breakfast and lunch recipients
4) Baby born to a mother under 20 with no high school diploma
5) Sibling arrest
6) Sibling who is a victim of abuse or neglect
7) Stressfulness in the social environment
8) Parent-child separation
9) Lack of parent and child bonding
10) Family economic stress
11) Loss of insurance, insurance that does not cover a specific condition or insurance with high co-pays
12) Lack of access to healthcare
13) Criminal arrest in family
14) Parent incarcerated
15) Neighborhood disorganization (crime, gangs and drugs)
16) Parental abuse of drugs and alcohol
17) Children of parents with serious mental illness or developmental disabilities
18) Children with autism or serious emotional disorder

IV. Children At Imminent Risk:
1) Victim of abuse, neglect or other crime
2) Truancy and academic failure
3) Delinquent act
4) Child use of drugs or alcohol
5) Probation or parole violation
6) Children aging out of the foster care system

V. Children In-Risk:
1) Children in state operated facilities
2) Commitment to the Department of Correction
3) Children in-patients in private hospitals with private pay
4) Children in private detention and treatment centers
5) Parole Violators

VI. Organizational At-Risk Indicators:
1) Lack of appropriate workload standards
2) Absence of or inadequate staff orientation and training
3) Lack of child and family needs assessment
4) Lack of needed agreements among service providers
5) Inadequate public education and information and outreach
6) Inadequate funding to support service needs
7) Lack of clear agency policy and guidelines
8) Un-timely approval of provider certification or licensure
9) Inadequate provider reimbursement rates
10) Cumbersome process to receive provider payments
11) Insufficient cash flow to manage the agency
12) Un-timely payments to providers
13) Absence of a quality assurance process
14) Inadequate staff supervision
15) Low staff retention
16) Inadequate information system
17) Untimely eligibility determination
18) Inadequate or unresponsive appeal process
19) Inappropriate case management review process
20) Non-compliance with Federal and state program requirements, including inadequate record-keeping and adherence to financial criteria resulting in loss of funds
21) Lack of effective local interagency coordination
22) Lack of a person centered and family centered decision-making process

"The number of risk factors is more predictive of "at-risk" results than any one factor by itself or any combination of several.

3.4.2 The following action falls under the responsibility of the Office of the Governor

Problem: Most Hoosier children are born healthy and experience physical, mental, emotional, developmental, and academic outcomes, free from abuse, neglect, or involvement in the juvenile justice system. Hoosier children who do not experience these outcomes often enter a public system of services and may fail to reach their full potential. The number of children who could experience these well-being outcomes can be increased through the promotion of first trimester healthcare, on-going prenatal care, and needed support provided by healthcare and other service professionals. While the importance of these services is well-documented, budgetary constraints often limit scarce resources to be directed to older children who are involved in more intense or traumatic situations. This focus on the older child creates an on-going need for more costly services, because prevention or early intervention services were not available. Research indicates that the later the intervention, the greater the likelihood that the intervention will be less effective, and more costly.

Action: The Governor must issue a clear statement that identifies an on-going commitment by the State of Indiana to early identification and assessment of children who need services as well as a comprehensive prevention and early intervention strategy for Hoosier children. The Indiana Family and Social Services Administration should develop and implement a strategy to maximize the benefits available through the EPSDT component of Medicaid, and utilize the statutorily authorized Early Intervention Teams in each Indiana county as a local planning group to develop and implement community-based prevention and early intervention strategies that identify and assess children for needed services at age appropriate intervals and other appropriate times. The Indiana Family and Social Services Administration should provide the forum and infrastructure to determine the manner in which current funding for services can be maximized so as to expand and improve prevention and early intervention services. This strategy should promote: comprehensive (physical, nutrition and mental) care for the mother; child development information and education for parents; parenting support services to foster self-confidence and competence in parenting, on-going physical and mental healthcare for the mother and the newborn; developmental screens for children; risk assessments for families with children; aggressive enrollment of children into these needed services; implementation of an outreach plan that promotes access and utilization of these services; and maximization of Federal reimbursements for Medicaid eligible services.

Target Population. Those who would be affected by the preventive service Action s are pregnant women and children ages 0-5 years. Children ages 6 to 18 years would be most affected by early and on-going intervention services such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Policy Outcomes. Prevention and early intervention services promote beneficial well-being outcomes for children. These services are almost always less expensive than out-of-home placement and provide greater choice for parents and families to receive services in their own home environment and in the community. The utilization of re-directed funds from higher cost alternatives to support these services would reduce or possibly eliminate the need for additional appropriations. Moreover, the existence of such a policy would encourage the reduction of

administrative costs, promote inter-agency collaboration and cooperation, and endorse the establishment of standards and automated information systems that would improve efficiency.

System Barriers. Multiple state agencies administer similar programs but in very different ways, without sharing common points of entry, standards of service, funding streams or policy orientations. Strong administrative leadership with support from the Governor's Office will be required to ensure that the interests of all stakeholders are carefully balanced. State agency staff may be resistant to designing and implementing necessary changes. Multiple computer systems changes will be required. The affected population will need to be carefully monitored during periods of transition to ensure that services are not interrupted or adversely impacted through unintended consequences. New educational and training modules will need to be developed. Medicaid Waiver amendments to the Federal government may be required to effectuate the changes, a third party evaluation must be initiated to ensure the changes meet the intended policy outcomes, and service delivery development must overcome the categorical program requirements of specific funding streams that result in "stovepipe" thinking.

Responsible Agency(ies) *and Action Steps:* The Governor should establish prevention and early intervention services as a necessary and critical component of a home and community-based service delivery system for children. The Indiana Family and Social Services Administration should be instructed to collaborate with the Indiana Department of Health, the Indiana Department of Correction, the Indiana Judicial Conference, the Indiana Judicial Center, and the Indiana Department of Education to develop a common policy that promotes the Governor's policy on prevention and early intervention. Common points of entry are developed and implemented most effectively through common intake formats and processes. Common standards of service must be established and implemented after a consistent and holistic service and needs assessment is performed. A state and local partnership should endorse the expansion, access, and utilization of First Steps, Healthy Families, Women, Infants and Children (WIC) Head Start, affordable and quality childcare and Hoosier Healthwise for all eligible families. Public information and outreach should make these services known to eligible families. The Indiana Family and Social Services Administration also should:

- Maximize the benefits available through the EPSDT component of Medicaid;
- Train all line workers and their supervisors on a holistic approach to prevention and early intervention services;
- Utilize the Early Intervention Team statute to serve as the initial community planning forum for the development and implementation of early identification and assessment of children, prevention and early intervention services;
- Collaborate with other state agencies both within and beyond the authority of the executive branch must be achieved that promotes the number one national education goal, that "children go to school ready to learn";
- Determine how funds from the Indiana Criminal Justice Institute, the Indiana Department of Correction, the Department of Health, local court systems, the Indiana Department of Education, and the Indiana Family and Social Services Administration can be maximized to serve children more effectively rather than by categorical funding stream requirements; and,
- Develop a monitoring system that tracks key indicators or benchmarks to measure the progress of this strategy commitment.

Fiscal Impact. This Action should be a component of the strategy to develop statewide access to unified systems of care for all children by June 30, 2007. In this manner, funds could be redirected to ensure that prevention and early intervention strategies can be implemented without jeopardizing current services and intervention for children at risk or currently in out of home

placements. Additional appropriations from the Federal government may be needed to expand certain services, but expansion of these services and state share for these services can be managed within approved budgets by monitoring utilization and constant tracking of existing appropriations.

Targeted Completion Date: The re-direction of priorities to early identification and assessment and prevention and early intervention strategies should be completed by December 31, 2008.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

Key Benchmarks - The percentage change in the number or amount of:

1. Children at "imminent risk" or "in-risk" served in a unified system of care.
2. Eligible children under 18 accessing EPSDT services.
3. Women receiving first trimester healthcare.
4. State and Federal funds used to support in-home and community-based services in comparison to all related expenditures.
5. Average length of time in long-term care facilities for children under 18 (or 21, depending on services)
6. Probation departments, child protective service offices, schools, and courts utilizing mental health pre-screening and/or family strength based assessment instruments.
7. Medical, dental, and mental health providers enrolled in the Medicaid program.
8. Expansion of Medicaid funding for services utilizing existing dollars for match.
9. Children's cases managed by the line workers in the child protective, juvenile justice, developmental disability, special education, and mental health systems.
10. Implementation of a comprehensive quality assurance system that references the system of care framework and addresses the quality of service provision, the timeliness of system response to client and agency needs, and an on-going cost-benefit analysis.
11. Children who are in out of home care that can move into their new "educational home" within an immediate timeframe and as agreed upon by child welfare, juvenile justice, mental health, child developmental, and education professionals.

Lead Benchmarks - The percentage change in the number or amount of:

1. Appropriately-aged children enrolled and using services offered by Healthy Families, First Steps, Women, Infant and Children (WIC), Head Start, Hoosier Healthwise and who transition to waivers with continuous services in a timely fashion.
2. Children under the age of 18 in institutions or children enrolled in special education.
3. Use of the IV-E waiver, the Home and Community-Based Services waiver, the Medicaid Rehabilitation Option and other funds that enhance healthy child development and that leverage additional Federal funds.
4. Number of local unified systems of care in Indiana, the number of Memoranda of Agreement signed by communities involved in these systems and the number of staff trained in the unified system of care concept.
5. Administrative funds directed to the development of the unified system of care infrastructure.
6. Number of service providers licensed, certified, or accredited by state and national standards.

Chapter 4. Issues

In reviewing the system and program issues and obstacles that were considered in the evaluation of the Actions presented in this Report, it became apparent that there were many issues that either fell outside the charge of the Commission and the individual task forces, or that required resources beyond the scope of this project and process. These issues are, however, both substantive and essential for fulfilling the goal to improve and expanded and community-based services in Indiana.

This section describes each of those essential issues and provides insight to the importance of each. It does not provide a specified set of actions, but rather serves to document that the Commission, the Task Forces, and the Consumer Advisory Committee understand the importance of each to overall system reform and feel compelled to communicate that to the Governor, the Legislature, and other stakeholders.

Those issues considered to be most essential are briefly described in this Chapter.

4.1 Quality Assurance

The shift away from traditional institutional modes of care to community-based services introduces many new opportunities for consumers and program administrators while simultaneously providing a whole host of quality assurance challenges. Unlike highly-regulated institutional care services, services provided in the community generally lack formal regulation and depend upon quality assurance protocols that are unique to each state. While states are given some Federal guidance regarding quality assurance expectations, they are also given wide latitude in their quality assurance methods. With respect to the Medicaid home and community-based services waiver programs, the Centers for Medicare and Medicaid Services require states to provide the following general assurances as a condition of waiver approval[25]:

- For the health and welfare of waiver participants;
- For plans of care responsive to waiver participant needs;
- That only qualified providers serve waiver participants;
- That the State conducts level of care need determinations consistent with the need for institutionalization;
- That the State Medicaid Agency retains administrative authority over the waiver program; and
- That the State provides financial accountability for the waiver.

Some examples of the unique challenges that quality assurance programs must take into account are:

- Direct oversight of the provisions of services may not be feasible where there are a large number of locations, some with as few as one person served.
- The type of direct oversight of service delivery found in institutions would be inconsistent with the spirit of the Medicaid Waiver Program itself, a program designed to allow people to avoid institutionalization.
- Structural characteristics of the current home and community-based healthcare sector such as limited opportunities for training and career advancement and the level of wages and benefits

provided staff in contracted programs may lead to high staff turnover or low staff awareness of home and community-based services program values.
- Because of the diversity of home and community-based services programs, a quality assurance program that is effective for one program may be unsuited for another.

Although the incorporation of a comprehensive and reliable quality assurance program into community-based services programs seems so obvious, many states and programs have, in fact, fared poorly in their program reviews. This poor performance can be attributed to many things, including: too-rapid growth in the program; lack of funding targeted to quality assurance; over-reliance on community care providers; lack of clear program definitions and quality expectations; lack of appropriate training, and lack of dedicated staffing.

It is for all these reasons that the Commission and the Task Forces wish to emphasize that *all Actions included in this June Report and the Interim Report presented in December 2002 must be accompanied by a full, appropriate, reliable, and on-going quality assurance protocol/process. This protocol/process must be fully established in both the design and implementation of each action. Moreover, successful implementation of each action is absolutely dependent upon a strong and reliable quality assurance component.*

4.2 Training and Outreach

Similar to quality assurance, each action presented by the Commission (and any significant policy change, for that matter) must be accompanied by a comprehensive and concise training and outreach plan. A sound training and outreach plan should have the following components:

- Formal, organized written and/or oral training for program staff.
- Formal, organized written and/or oral training for consumers and their families and caregivers.
- Formal, organized written and/or oral training for providers.
- Determination of and effective outreach for training location and dates.
- Determination of training frequency.
- A mechanism for updating the training materials in a timely manner, as needed.
- Some method for determining whether the training has been successful; i.e., training survey; outcomes analysis, error rates, etc.

Materials should be brief and easy to read, and the information should be accurate and complete. In addition, the Commission strongly advocates the use of web-based information to supplement (not substitute for) other written and oral outreach efforts.

4.3 Service Access

While it is obviously important for community-based services and processes to expand and improve to accommodate an increasing number of consumers and providers, it is no less essential that eligible persons are able to plan for and begin receiving services as quickly as possible. Depending upon the state, waiting lists may or may not be an acceptable method of managing program expenditures.

Through early Commission meetings, it became clear that there is not agreement about how "single point of entry" is defined. For example, it could mean any of the following:

- Consumers work with one (and only one) entity that determines eligibility, arranges for, and obtains necessary services;
- Consumers may choose from one of several entities that determines eligibility, arranges for, and obtains necessary services;
- Consumers may work with more than one entity to determine eligibility, arrange for, and obtain necessary services; but one application/intake form is used by all;
- Consumers may work with one entity, with eligibility determinations and other aspects of the process being determined by others "behind-the-scenes";
- Consumers may access one or more physical locations for the application process, eligibility determination, service planning, etc.;
- The physical location is wheelchair accessible and has adequate parking and a safe drop-off area.

Regardless of how access is defined, a successful program is one that is responsive to the needs of consumers and that includes physical environment considerations, easy-to-understand and complete application and information-collection forms, short processing times, and friendly and caring staff.

4.4 Interagency Coordination

Successful policy changes and community service program expansions depend upon strong communication between, and collaboration with, state agencies and program staff. Failure to have that foundation in place causes considerable consumer and provider upheaval and confusion, administrative inefficiencies, duplication of effort, and costly outcomes.

Poor coordination between state agencies and program staff may be attributed to: reluctance to relinquish decision-making authority; disagreements about philosophy, program, or process issues; resistance to policy changes; and differences in priority and/or level of commitment (agency investment).

Because this is an issue common to both government and the private sector, yet basic to the goal of improving systems and achieving significant and lasting efficiencies, each of the twenty-eight (28) new Actions presented by the Commission in this Report assumes that all program staff and other stakeholders understand the necessity and value in collaboration and consolidation of effort, and will commit themselves to resolving these long-standing interagency coordination barriers to the greatest extent possible.

4.5 Consumer Choice

The term "consumer choice" may have many meanings. It may refer to a consumer's ability to exercise free will when making decisions, or to a consumer's personal selection of a caregiver or service, or it may even refer to the establishment of a full array of services within a continuum of care so that all service options are available to the consumer should the need arise.

All of these meanings are incorporated within the twenty-eight (28) new Actions presented in this Report. It is the goal of the Commission to help the State to fill in the gaps within the existing array of services, promote greater consumer involvement in his/her care plan, and allow the consumer the opportunity to personally select, hire, and fire his/her own caregivers. In addition, while the primary objective of the Commission is to promote greater consumer choice and independence by expanding and improving the opportunities for consumers to receive care in a community-based setting whenever safe and feasible, it does not advocate in any way the elimination of institutional care as a valued and important service within the long-term care continuum.

Another similar, although somewhat different focus of the Commission, is to especially highlight the specific Action that promotes the establishment of a consumer advisory council. It is this Action especially that establishes a formal consumer advisory body that should assist the State on developing policy and program improvements and changes that will directly and indirectly affect the lives of consumers. This, too, may be considered an extension of the goal to promote greater consumer choice, since it seems reasonable and intuitive that policies, which are designed to serve and benefit consumers, should not be made without calling upon the persons most affected by those policies for input and confirmation. Longstanding models already exist with respect to collaborating with providers and incorporating their concerns and issues into the policymaking process, therefore, the formal establishment of consumer input in Indiana should be a logical extension of public policy development.

4.6 Affordable and Accessible Housing

It has been recorded many times in this document and within numerous publications generated by the state, local, and Federal governments that affordable and accessible housing is in very short supply. In fact, current data indicates that there are currently 3,700 households receiving housing assistance through Indiana's Housing Choice Voucher Program (Section 8), two-thirds of which have elderly or disabled members. This compares to a very high demand for this assistance with over 7,000 households on the pre-application list waiting for assistance[26]. It is for this reason that the issue of housing warrants special attention and cannot be fully resolved with the identification of a few critical actions.

Most notably, it is essential that all stakeholders understand that the lack of affordable and accessible housing has a chilling affect on achieving desired outcomes throughout the rest of the long-term care service delivery system. Namely, without affordable, accessible housing, the State will be extremely limited in its ability to de-institutionalize, and divert from institutional care, large numbers of people. This is because, while in institutions, consumers are receiving not only care, but also housing, both of which may be covered (and paid) by Medicare and/or Medicaid. In contrast, however, once consumers are discharged from an institutional setting, neither Medicare nor Medicaid is permitted to cover housing. Further, publicly-funded housing is in extremely short supply and has its own set of rules and restrictions. As a result, if development of new housing initiatives is not aggressively pursued, the State is likely to find itself in the position of having developed a plethora of new service options yet have no consumers to utilize them. Diverting people from institutional care poses less of a problem, since many of those consumers will continue to reside in their own homes, if given the opportunity. The problem with the diversion population does, however, present itself when the consumer can no longer live on his/her own and requires additional assistance that others cannot or will not provide.

It is for these and many other reasons, that the development of strong, effective, and large assisted living and adult foster care service programs becomes essential. These two programs offer both publicly-funded services and residential care, therefore investment in both resolves not only a service demand problem but also responds to the serious affordable, accessible housing shortage. It is important to note that the state leaders in community-based care throughout the country all have significant, viable, and flourishing assisted living and adult foster care programs. Without these two services, it is impossible for Indiana (or any state) to meet all of its home and community-based services goals.

4.7 Provider Capacity

Similar to the need for affordable, accessible housing is the need for a strong and reliable provider base. Without a solid provider base, Indiana cannot succeed in providing true consumer choice and will not succeed in shifting the long-term care service balance from traditional, institutional modes of care to community-based care.

Ensuring sufficient provider volume and quality requires the following basic elements:

- A formal provider recruitment strategy that includes outreach, training, follow-up, responsiveness, and access (to program staff).
- Clear provider guidelines and frequent performance feedback.
- Timely and well-understood payment processes.
- Reasonable rates that include regular inflationary increases.
- A rate structure that is based on both cost and competitive prices.
- A mechanism that provides retention assistance to institutional providers who wish to transition their services to those which are community-based.

While provider rate issues are currently targeted for budgetary discussions and possible reductions, it is extremely important to note that Indiana cannot make the shift to community-based services without investing in the provider base. Accomplishing true system reform will require some level of investment (a new expense) up front. If, however, that investment is carefully monitored, then savings in the longer-term, accompanied by a significant and cost-effective increase in the number of people served, can and should be expected. The Commission strongly encourages the Governor and State Agencies to refer to the Caregiver Commission Report (2002), which provides an excellent resource for provider issues and opportunities for resolution.

4.8 Federal Barriers

Many public assistance programs have a number of specific limitations or barriers that hinder their ability to meet consumer's needs. Some of these originate in the state or local administration and can be changed through the normal policy, rule, or legislative process. In contrast, Federal barriers are much more difficult to change for many reasons, including: the Federal government serves a much larger constituency; change is much more time-consuming and difficult to implement; unique state issues generate little interest nationally; consensus is more difficult to achieve; etc. One significant example of a Federal barrier that severely limits a state's ability to deliver cost-effective services is the prohibition of using Federal Medicaid matching funds for the costs of any Medicaid covered services furnished to an individual who is

under 65 years of age who resides in an institution for mental disease (IMD). This Federal policy creates a significant gap in funding and services for persons with mental illness that few states have effectively overcome.

Despite all of those reasons, recent and significant changes at the Federal level, delivered under the auspices of the *Olmstead* decision and the President's New Freedom Initiative, have created an impetus for change that the states have never before seen. As a result, it is imperative that Indiana work aggressively with other states (i.e., through the National Governor's Association, National State Medicaid Directors Association, etc.) to influence Federal policy, as well as to aggressively pursue any and all Federal grant initiatives that are available.

Indiana's efforts in pursuing Federal grant opportunities have, in the past, not always been stellar, so it is absolutely essential to the effort to expand and improve community-based services that the State invest and direct resources to these new opportunities. Not only does this present Indiana with the opportunity to leverage additional funds during extremely lean years, but it also improves the chances for Indiana and the other grantee states to collectively and effectively influence change at the Federal level.

Chapter 5. Going Forward

In addition to the recommendations presented in the Interim Report and the Actions prescribed in the June 2003 Report, a number of additional steps remain that will require definitive action in the future. These steps are not as easily defined, and may not be easily assigned timeframes and evaluation criteria since they depend upon a number of unknown factors. These unknowns include: changes in policy direction; changes in resource allocation; new or revised Federal mandates; or changes in staff capacity, organizational structures, and accountabilities.

Nevertheless, these actions can and must be defined in a way that provides the guideposts for continuing the direction, keeping the focus on systems change, and providing guidance for future leaders who will be responsible for completing the tasks.

The Going Forward actions are as follows.

5.1 The Role of the Regional Planning Councils

Meaningful change in system implementation will depend on an active and involved provider and advocacy base at the local level. Regional planning councils were first conceived by the State Operated Facilities Council and were intended to provide a forum and basis for creating this involvement. It is recommended that the eight (8) established Councils be charged with evaluating their current provider and community agency base to determine whether or not the existing capacity can accommodate the goal of serving all people in their setting of choice. If it does not exist, the Councils should assume the responsibility for defining more specific strategies for fulfilling this need.

It is further recommended that each Council evaluate its own unique response to the Actions presented in this report and the Caregiver Commission Report to determine what community resources can be generated, what strategies can be developed, and what support services can be modified to create meaningful and sustained systems change, one community at a time. Examples might include utilizing local philanthropic dollars for specific projects or petitioning the State for a demonstration project that coordinates services in a way to better serve people at risk of being institutionalized. It might also include involving a community hospital to strategically and systematically develop discharge-planning policies that support community options over a long-term care option.

5.2 Quality Assurance Systems

There must be a meaningful analysis of the quality assurance systems needed to provide a framework for community-based services, but also an adaptable implementation plan that will allow it to grow and improve as the services and consumer population expand. Clearly there will need to be a comparative evaluation of the quality assurance systems in place for the institutional service settings and the quality assurance systems that are expected and already in place for the community-based settings. The two have many differences, including: regulatory requirements; oversight responsibilities; reporting and accountability; philosophical approach; staff qualifications; and others.

There will need to be effective and routine collaboration between those government entities responsible for institutional oversight (e.g., the Indiana State Department of Health) and those responsible for community oversight (e.g., the Indiana Family and Social Services Administration) to ensure that there are no gaps in quality assurance activities and that standards are modified and evaluated commonly as the service delivery system becomes more balanced.

5.3 Federal Barrier Changes

Through the President's New Freedom Initiative, there will be continued emphasis on supporting states in developing community service options as an alternative to institutional care. In part because of the *Olmstead* Decision, the Federal government has recognized the inconsistencies of its own policies and funding streams that all too often create barriers for people who wish to live in the community with the appropriate support services. Indiana should capture the moment and pursue every opportunity to influence Federal policy changes whenever and wherever appropriate and possible.

5.4 On-going Evaluation through the Benchmarks and Report Card

As stated previously, the Governor's Commission on Home and Community-Based Services was created to examine, plan, and recommend short- and long-term actions that will significantly improve the system of long-term supports and services for persons who depend upon public assistance and who are disabled, who have mental illness, and who are at risk of institutionalization or are already institutionalized. These actions are absolutely essential for shifting the balance of publicly-funded care from traditional institutional modes of care to service settings and options that are community-based and more responsive to consumer choice, independence, and dignity.

For this effort to be sustained over time, it is imperative that the recommendations and actions developed by the Commission are tied to benchmarks designed to accurately describe and measure the change(s) and communicate progress to policy makers, decision makers, consumers, providers, and advocates.

Please note that the following benchmarks are intended to measure Indiana's *overall performance* in balancing the long-term care service delivery system over time; they are not intended to specifically measure the policy outcomes of individual recommendations and actions developed by the Commission.

1. Percent increase over time of Medicaid long-term care dollars spent on community-based services compared to institutional services.
2. Proportion and percent increase of Medicaid long-term care dollars spent on consumer directed care.
3. Percent decrease over time in the average number of days for eligibility approval for all Medicaid Home and Community-Based Services Waiver programs.
4. The percent increase over time in the number of persons receiving home and community-based services (both Medicaid and state-funded programs) compared to a percent decrease over time in the number of persons in institutions.
5. The number and percent increase over time in persons with mental illness who receive community and residential service supports compared to institutional services.

6. The number and percent increase over time of persons served by the Medicaid Assisted Living Waiver.
7. The number and percent increase over time of persons served in Adult Foster Care settings.
8. The number and percent increase over time of adult day service centers statewide.
9. The number of and percent increase over time in new housing initiatives.
10. The number and percent increase over time of persons served by existing housing initiatives.
11. Percent increase over time in the number of and geographic distribution of public transportation providers.
12. Percent increase over time in the utilization of specialized transportation services.
13. Percent increase over time in the number of and geographic distribution of public/private employment partnerships.
14. Percent increase over time in the employment rate for persons with disabilities.
15. Percent increase over time in the employment retention rate for persons with disabilities.
16. Percent increase over time in the number of integrated employment placements for persons with disabilities.
17. The number and percent increase over time of persons with disabilities who self direct their care.
18. The number and percent increase over time of eligible children under 18 years of age who access Medicaid-funded Early Prevention Screening and Diagnostic Treatment (EPSDT).
19. The number and percent decrease over time in the incidence of children with alcohol and/or drug abuse.
20. Percent increase over time in the number of children under 18 years of age who receive care in the community compared to the percent decrease over time in the number and length of stay of children under 18 years of age who receive care in institutions.
21. Percent increase over time in the number and incidence of children who are under 18 years of age and who receive successful community interventions that lead to a decreased number and incidence of children who enter the child protective or juvenile justice systems.
22. The number and percent increase over time in the utilization of a mental health pre-screening instrument and child and family strengths assessments by probation departments, children protective service offices, schools, and courts.

It will be incumbent upon each State Agency to establish the baseline data against which change to the system can be measured. Where it does not exist, the lead agency or office should take responsibility for developing it as a means of providing the necessary accountability for real systems change. It is further assumed that this report card will be adopted by key stakeholders as a means of holding specific state agencies and providers accountable for creating change.

States are typically not good at or accustomed to evaluating policy changes and new initiatives to determine the level of success of the initiative and to formally measure the outcomes. As a result, successes and failures are not well-documented, and opportunities to learn from mistakes are lost. Moreover, program and/or process problems are not modified when improvement opportunities are identified, so policies that do not make sense may remain in place for far too long.

To resolve this common problem, the Commission strongly recommends that the Actions presented in this report be regularly evaluated. Specific benchmarks for each Action have been developed, and are intended to accompany the general, overarching benchmarks described above to assist in determining the overall success of long-term care service reform.

5.5 Consumer Participation

While many services and programs are specifically targeted to consumers, their involvement in policy development, program design, and implementation is not typically sought. As a result, programs and policies are often unintentionally flawed in ways that are not readily apparent to the policymakers. To resolve this long-standing problem, the Commission believes strongly that consumers need to be incorporated into all aspects of service delivery. As the State shifts from an institutional focus of care to one that is driven by consumer choice and community partnership, it is the perfect time to fully incorporate consumers into the process. One way to do this is to convene a consumer advisory council to assure formal, regular inclusion of the consumer perspective into policy and program development. Another way is to solicit written input from consumers as draft policies and program manuals are developed. And yet another way is to develop regular and targeted consumer surveys to evaluate progress, identify system inefficiencies and flaws, and identify necessary program and/or policy modifications.

In the past, providers were the only or primary stakeholder that regularly communicated with state staff and/or were invited to participate in policy development. In addition, while the reasons for including providers are clear, it can be considered no longer acceptable or reasonable to exclude consumers from the process. Consumer issues demand consumer input, so a formal strategy for incorporating that perspective must be developed immediately and effectively administered.

5.6 Additional Efforts through the President's New Freedom Initiative

The President's New Freedom Initiative has already provided significant grant opportunities and funding to any willing state that is committed to pursuing reform in its long-term care service delivery systems.

This initiative continues to gain momentum and will soon present itself in a second round of grant opportunities available to the states. These new opportunities are specifically targeted to continue the work already undertaken through the first round of grants, as well as to introduce several new initiatives that will provide impetus to some consumer-driven programs that have not been widely implemented to date.

Not only do these grants help Indiana to further meet some of its longer-term goals, but they also provide a unique opportunity to generate new funds within a very challenging budgetary climate. The new initiatives highlight the possibilities for change and provoke states to seize those opportunities and pursue change when older, more costly and less desirable approaches can no longer be sustained. Further, valuable technical assistance is available and can provide guidance that can be specifically tailored to meet each state's needs.

Finally, it is important to note that budgetary constraints need not prevent the State from making progress, but instead can and should be (and has been in other states) a nesting ground for reform. The President's New Freedom Initiative was developed during a low economic period nationally and is specifically intended to help provide the momentum that states (and the Federal government) need to make the policy changes necessary to move public assistance programs forward. As a result, it is imperative that the State of Indiana pursue the additional grant opportunities that are available this year and in subsequent years. Indiana stakeholders and the Office of the Governor in particular should influence the congressional delegation to include

those resources in the President's proposed budget in the U.S. Department of Health and Human Services to be considered by Congress later this summer.

5.7 Lessons Learned from Best Practices

There is now considerable documentation that is available to states that conveys best state practices and provides program and process models that can be easily replicated. During this time when state resources have reached their limits, it is even more critical that staff time not be wasted in designing or implementing programs or policy changes for which successful models are available.

Examples of successes and failings should assist the State in targeting its efforts and avoiding costly design error and implementation flaws. It also places the State on a fast-track to obtain Federal approval on a new program or design that has already been approved somewhere else. Indiana should systematically review these efforts and evaluate the practicality and adaptability of the success that other states have in moving toward rebalancing their systems of care.

5.8 Structural Support for Interagency Coordination

While the shift from institutional care to community-based care has been extensively described in this report, it is especially important to note that success of that shift will depend upon a "meeting of the minds" between all state agencies involved in the process. This can be accomplished through the establishment of a formal mechanism that provides the structural support for interagency collaboration and coordination, which does not exist currently.

Success will depend upon collaborative planning, agreement on priorities, pooled resources, shared responsibility, and frank and open evaluation. Support for the interagency coordination will need to be provided from the "top down", with the decision-making occurring from the "bottom up", to the greatest extent possible. This will need to occur not only between the various divisions of the Indiana Family and Social Services Administration, but also between the agencies that are responsible for the services that will make the Actions presented in this report a reality throughout the State.

A significant opportunity exists in the potential coordination of Actions among two additional commissions that have been established by the Indiana General Assembly and the Governor. The Juvenile Justice Commission was established in April 2003 by Executive Order and has as its purpose, the study of laws and processes for children in need of services and the juvenile justice system. It is felt that the study of the whole system, rather than just components of the system, can best serve the interest of children and public safety. The Commission has met once, with three additional meetings planned. A key component of the Commission will be to study the similarities and critical juncture points in the child protective, education, and juvenile justice system to determine how information can be shared on children served by more than one system and how services for children and their families can be assessed and funded. Similarly, the passage of Senate Enrolled Act 62 (2003) establishes a commission to develop an implementation plan for the establishment of a continuum of services for children at-risk of abuse or neglect by their family. Both commissions will require the active involvement and the engagement of the education system to ensure and promote the ability of children to succeed with proper educational

skills. When considered in conjunction with the Action on the development of systems of care throughout Indiana, it is clear that educational attainment must remain a priority to help a child in any of the three service systems.

An opportunity also exists to promote integrated recommendations among the three commissions. The importance of prevention, early intervention services, and academic success can be enhanced by each of the two subsequent commissions to build upon and reflect the systems changes that are made in this Report. This may include a collection and coordination of all recommendations from each of the commissions into a single report for at-risk children.

Chapter 6. December 2003 Meeting

The Commission will conclude its work in December 2003. The final meeting of the Commission has several purposes:

- First, the Commission will receive a report on the mini-grants. Because many of the projects will have six months or less of operational activities, the grant report will be a status report covering grant progress, the impact the project is having on the community, the clients served, and reduction of barriers to service. In addition, the grant report will include information on any potential success in developing ongoing support for those projects that expect to be self-sufficient.

- Second, the Commission will receive a report on the progress in accomplishing the recommendations in both the Interim Report and the action in the June Report to the Governor. This report will detail all successes and accomplishments as well as any barriers to progress. It is assumed that where the barriers to progress are defined, the assigned agency will provide detail on any mid-course corrections.

- And finally, the Commission will receive a report on the progress in implementing Senate Enrolled Act 493. This legislation promises to have significant leverage on shifting the balance from institutional care to community-based care.

The strength of any initiative like that of the Commission on Home and Community-Based Services is in the implementation strategy. Without such a strategy, the recommendations and actions often get lost or at best, even if they are accomplished, the success is not always attributed to the original recommending body. This contributes to the frustration that many believe that blueprints for progress or Commission charters are not successful.

While the relationship between the work of the Commission and the work of the Regional Service Area Planning Groups is still unclear, it is assumed that if there is to be a connection of implementing specific Commission recommendations and actions through these groups, the Commission will be interested in hearing how this is to take place.

In conclusion, the December meeting will be primarily a meeting to learn what successes have been achieved by specific state agencies and through the mini-grant projects. In addition, the Commission will learn about decisions that have been made with respect to implementing the recommendations and actions at the community level.

Chapter 7. Conclusion

This June 2003 Report is submitted to Governor O'Bannon for review and consideration by the Governor's Commission on Home and Community-Based Services. It includes a brief background of the relevant long-term care service delivery system issues, identification of the target populations, an overview of three Federal grant initiatives, a status update of the sixteen (16) Action s presented in the December 2002 Interim Report, an analysis of several critical Actions that are essential for accomplishing substantial and lasting change in Indiana's long-term care service delivery system, a discussion of critical issues, and presentation of several issues that must be considered as the State moves forward.

The twenty-eight (28) new Actions presented in this June Report, and the sixteen (16) Action s included in the Commission's Interim Report presented in December 2002, provide a template for the State of Indiana to achieve the long-desired shift in the balance of long-term care services for persons who are elderly, persons who are physically disabled, persons who are developmentally disabled, persons with mental illness, and children and their families who are at risk.

Each Action has been carefully evaluated and vigorously debated, and stands out as a policy change that is essential for the successful transition from traditional, institutional care to care provided in a community setting. Most are not simple to implement and will require thoughtful and dedicated planning, but all are certain to help the State meet its many goals and objectives.

The Commission ends this Interim Report to the Governor by restating how appreciative it is of the trust and responsibility given it by Governor O'Bannon. The Commission is committed to embrace innovation and motivate solid and lasting change for Indiana's consumers of long-term care services. It is the Commission's goal to build upon the work of others by establishing partnerships between public and private, linking affordable housing and services, and creating a structure and process for consumer and provider outreach, all of which are vital for shifting the balance of Indiana's long-term care service delivery system.

Endnotes

[1] Dick Ladd, August 8, 2002 Presentation to the Governor's Commission on Home and Community-Based Services, Indianapolis, Indiana.

[2] "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century", Robyn I. Stone, pages 5-6, Milbank Memorial Fund, August 2000.

[3] OFFICE OF MEDICAID POLICY AND PLANNING Annual Report 2000, pages 10 – 11

[4] "Statewide IN-Home Services 2000 Annual Report, July 1, 1999 – June 30, 2000", page 9.

[5] The Centers for Medicare and Medicaid Services, or CMS, is part of the U.S. Department of Health and Human Services.

[6] "*Olmstead* and Supportive Housing: A Vision for the Future", CHCS Consumer Action Series, Ann O'Hara and Stephen Day, Technical Assistance Collaborative, Inc., December 2001, page 5.

[7] Robert Wood Johnson Foundation. "A National Study of Adult Day Services 2001-2002"

[8] According to the Robert Wood Johnson Foundation, consumers that can have their needs met in adult day services, do so at approximately a quarter of the cost of institutional care.

[9] Home and Community-Based Services Resource Network, www.hcbs.org.

[10] SFY 2003 data, "Expenditure Forecast: FY 2000 – FY 2005", Office of Medicaid Policy and Planning, April 10, 2003

[11] Office of Medicaid Policy and Planning, June 6, 2003.

[12] "At risk" is typically defined as someone who experiences three hospitalizations and/or inpatient nursing home/rehab services within a 12 month period.

[13] 42CFR435.911(a).

[14] According to an analysis completed by two area agencies on aging, approval for the Medicaid Aged and Disabled Waiver took an average of 107 days.

[15] Bureau of Aging and IN-Home Services, Indiana Family and Social Services Administration.

[16] The Kaiser Commission on Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", page 169.

[17] Indiana Division of Mental Health and Addiction Hospital DSS.

[18] The Division of Disability, and Rehabilitation Services reports that currently 70% of RBA recipients have mental illness.

[19] U.S. Department of Health and Human Services (1999)," Mental Health: A Report of the Surgeon General", Rockville, Maryland.

[20] Report from the Indiana Division of Mental Health and Addiction, 2002.

[21] 42 CFR 435.1009.

[22] Centers for Medicare and Medicaid Services website.

[23] Lee Moon, PhD., Indiana Vocational rehabilitation Services.

[24] David Perkins, PhD, Ball State University.

[25] "Quality Assurance in Home and Community-Based Services Waiver Programs: A Guide for States", December 2001, National Association of State Medicaid Directors.

[26] Governor's Commission on Home and Community-Based Services, Indiana Fact Book, May 21, 2003 version, page 38.